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ABSTRACT

This collection of articles summarizes what mental health professionals have learned about evaluating and treating infants and young children who have been exposed to violence in their homes and communities. Emphasis is on recognizing symptoms and behaviors demonstrated by very young children who have been exposed to violence, supporting caregivers of traumatized young children, and designing and carrying out treatment plans. Following an introduction by Joy D. Osofsky, the following articles are offered: (1) "Evaluation of Posttraumatic Symptomatology in Infants and Young Children Exposed to Violence" (Charles H. Zeanah and Michael Scheeringa), which describes the range of symptoms and behaviors typically seen in these children; (2) "Developmental and Therapeutic Aspects of Treating Infants and Toddlers Who Have Witnessed Violence" (Theodore Gaensbauer), which uses a detailed case example to illustrate the evaluation and treatment process; (3) "Trauma Reverberates: Psychosocial Evaluation of the Caregiving Environment of Young Children Exposed to Violence and Traumatic Loss" (Marva L. Lewis), which offers a comprehensive approach to evaluating the child's environment; (4) "Children without Refuge: Young Witnesses to Domestic Violence" (Betsy McAlister Groves), which addresses issues in the evaluation process such as the tension between the needs of children and adults; and (5) "When the Helper Is Hurting: Burnout and Countertransference Issues in Treatment of Children Exposed to Violence" (Joy D. Osofsky), which offers guidelines for training and supporting front-line clinicians and collaborating effectively with other community professionals. Descriptions of 10 related videotapes are also included. (Contains 62 references.) (DB)

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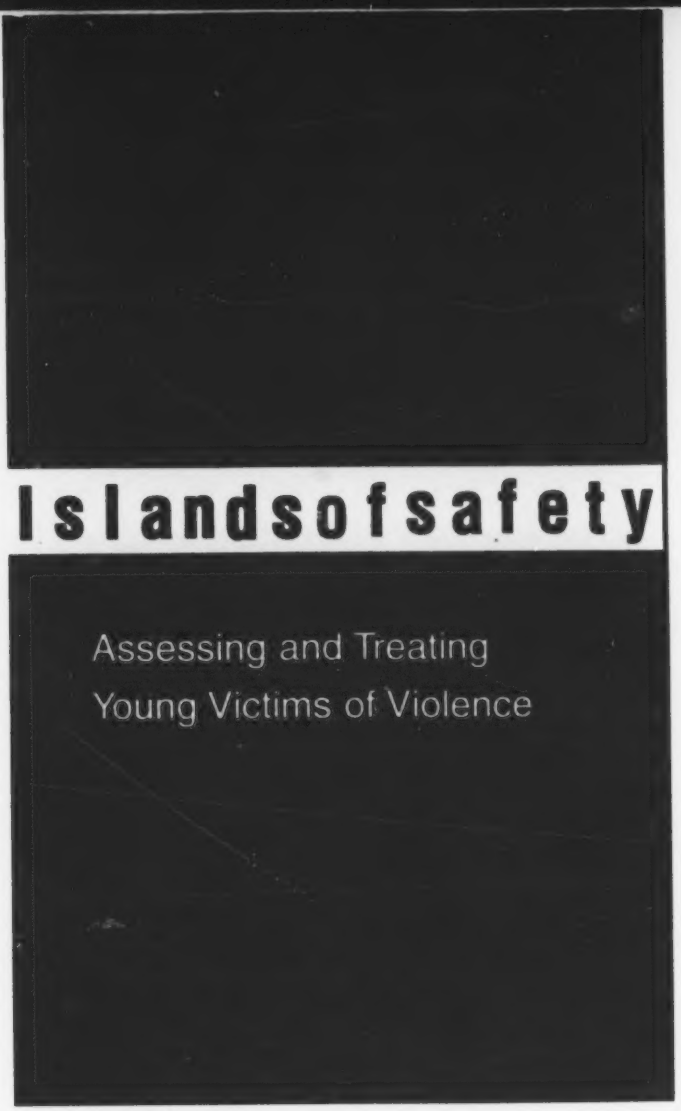

Islandsofsafety

Assessing and Treating Young Victims of Violence

Joy D. Osofsky and
Emily Fenichel, *editors*

ZERO TO THREE

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ZERO TO THREE's urgent mission is to advance the healthy development of America's babies and young children. We strengthen and support professionals, policymakers and parents by: increasing public awareness; fostering professional excellence through training; inspiring tomorrow's leaders; promoting the discovery and application of new knowledge, model approaches and "best practices;" stimulating effective service approaches and responsive policies; and educating parents and other caregivers about significant differences they can make in the lives of babies and young children.

Matthew E. Melmed, *Executive Director*
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Haida S. McGovern, *Associate Director*

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Infants and young children can be overwhelmed by their exposure to violence, especially when both victims and perpetrators are emotionally important to the child.

Introduction

Joy D. Osofsky, Ph.D.

Every night, three-year-old David wakes up screaming and runs to his grandparents' bed. He can't describe his nightmares, but his grandparents are sure they are connected to the day 11 months ago, when David watched as his mother's boyfriend shot her dead. Caring for a traumatized toddler is not how David's grandparents planned to spend their retirement.

Once a week, for eight months, Julie has enacted this ritual in her therapist's office: She divides all the toy animals into "good" animals and "bad" animals, then places the two herds in opposite corners of the room, barricaded by furniture. Today, Julie asks the therapist to do something new—to "write sentences" for her. The sentences are: "My daddy hit my mommy and the Christmas tree fell down. I don't like it when my daddy is mean to my mommy. Don't be mean, Daddy. If my daddy hits my mommy again, I will throw my sweater at him and make him stop." Julie tells the therapist that she misses her father. He is barred by a restraining order from the home of his battered wife— and his daughter.

Larry is three years, 4 months old. Almost a year ago, when he was 29 months old, Larry saw his father shoot himself, fatally, in the head. Now Larry's mother has brought him to the Infant Mental Health Clinic because Larry won't stop talking about his father shooting himself. During the initial evaluation session with his mother and a male examiner, Larry picks up a toy gun, examines the trigger, walks over to the examiner and "shoots" him in the head, saying, "I'll kill you!" Then Larry says, "I'll kill my mommy!", walks over to his mother and "shoots" her in the head. Larry's mother pales, and the examiner asks her if she is all right. The examiner observes that although children he is evaluating often "shoot" him, Larry is the only child who has shot him in the head— obviously a result of what Larry experienced with his father.

Alexandra is a 19-month-old girl who has been referred for evaluation by child protective services because of significant developmental delays and her lack of discernable attachment to anyone. This pattern is unusual in a child who, like Alexandra, has been raised continuously by both of her parents; it suggests severe and chronic neglect. During the evaluation, the examiner presents Alexandra with some red cubes and asks her to make a tower. Alexandra first becomes frustrated, then suddenly becomes completely unresponsive. She stares blankly straight ahead, not only failing to respond to the examiner's eye contact, but also failing to respond to the examiner's voice or touch. The episode lasts for 15 seconds.

David, Julie, Larry, and Alexandria are coping, in the only ways they know how, with their experiences of violence—the use of physical force to injure or destroy. As babies or toddlers, these children witnessed violent death or serious threats to the safety of adults they loved. Other very young children are themselves injured—

Joy D. Osofsky, Ph.D.
Department of Pyschiatry
Louisiana State University School of Medicine
New Orleans, Louisiana 70112

once or repeatedly—by violent strangers, neighbors, or family members. Exposure to violence can have overwhelming and enduring effects on young children. But as the brief vignettes above suggest, adults who are caring for traumatized children often wait months or years before seeking help for children's symptoms. Wanting desperately to believe that babies and toddlers "can't understand," "won't remember," or "will get over" the violence they have suffered or seen, parents, caregivers, teachers, and health care providers try to cope with and contain children's behavior—until a little boy is "out of control" or a little girl stares into space a dozen times a day.

This publication presents what mental health professionals have learned about evaluating and treating infants and young children who have been exposed to violence in their homes and communities. Based on presentations at the 1995 National Training Institute of ZERO TO THREE: National Center for Infants, Toddlers, and Families (formerly the National Center for Clinical Infant Programs), it complements ZERO TO THREE's publication, *Caring for Infants and Toddlers in Violent Environments: Hurt, Healing and Hope* (1994). Generous support from the William Penn Foundation has enabled us to provide this urgently needed information as a special issue of *Zero to Three*, the bi-monthly bulletin of ZERO TO THREE: National Center for Infants, Toddlers, and Families, and as a free-standing report.

Islands of Safety is designed for many readers —parents, child care providers and teachers, police officers, community leaders and philanthropists, health and social service professionals, and mental health practitioners. The psychiatrists, psychologists, and clinical social workers who have contributed to this publication share what they have learned about: 1) recognizing the full range of symptoms and behaviors that may result from very young children's exposure to violence; 2) supporting the caregivers of traumatized young children (many of whom are suffering from their own experiences of violence and loss); and 3) designing and carrying out treatment plans—beginning, always, with securing a safe environment for the child and caregivers—to help young children cope with and recover from their experiences.

Children in a violent country

The United States is the most violent developed country in the world. Children, especially, are affected (Osofsky, 1995; Osofsky & Fenichel, 1994). Homicide is the eleventh leading cause of death for all Americans, but the third leading cause of death for all children between the ages of five and 14 (Children's Defense Fund, 1996).

School-age children witness violence and its aftermath in their communities every day. In a survey of sixth, eighth, and tenth graders in New Haven in 1992, 40 percent reported witnessing at least one violent crime in the past year (Marans & Cohen, 1993). Very few of the children escaped some exposure to violence, and almost all of the eighth grade children knew someone who had been killed. Elementary school children regularly witness violence. In a Chicago neighborhood, one-third of the school-aged children studied had witnessed a homicide and two-thirds had witnessed a serious assault (Bell & Jenkins, 1993). In a low-income Washington, D.C. neighborhood, 72 percent of children between 6 and 10 years old had witnessed some type of violence; in a similar but slightly more violent New Orleans neighborhood, 91 percent of fifth-graders had witnessed violence. Even more disturbing, 32 percent of the Washington, D.C. children and more than half (51 percent) of the New Orleans children reported being victims of violence (Richters & Martinez, 1993; Osofsky, Wewers, Hann, & Fick, 1993).

In our clinical work, we learn about the impact of these experiences: Taking her usual route home from school, nine-year-old Sharon came across a dead body on the street. (We later learned that the fatal shooting had occurred only a short time before; the police had not yet arrived to investigate or close off the area). Sharon ran the rest of the way home. For days, she cried and clung to her mother. She had repeated nightmares and refused to sleep by herself. She initially refused to go to school by herself, and when she did begin walking to school again, she went by a different route. Sharon's nightmares continued and she had trouble concentrating in school. Only after her mother was able to seek professional help to talk about her anger at the incident and support her daughter did the symptoms decrease.

Sharon's experience, in fact, was relatively mild: She did not know the victim; she did not witness the shooting itself; and her mother and other family members empathized with her dis-

tress, respected her need to avoid the scene of the trauma and withdraw temporarily from daily demands, and assured her of their ongoing protection.

For some children, exposure to violence is chronic and close to home. Many children who have been traumatized once become vulnerable, with each repetition, or even reminder, of the earlier experience, reactivating symptoms.

When Belinda was five years old, a bullet fired in a gun battle on the street entered the window of her house and wounded her on the leg. Belinda had nightmares and clung to her mother. Her mother brought her to a clinic where she received individual psychotherapy and her mother received counseling; the symptoms finally lessened over time. Two years later, police officers with guns drawn entered Belinda's home, looking for a drug dealer. They were gruff in manner and paid no attention to the presence of a little girl. When Belinda saw the guns, she began to scream. Her mother was at work and the other adults in the house explained Belinda's fear to the police officers, who said that she shouldn't be afraid of the police, but rather of the drug dealer they were trying to arrest. By the time Belinda's mother called the clinic a week later, Belinda was again willing to go to sleep only in her mother's bed and was waking up in the night with nightmares. Again, with individual psychotherapy for Belinda and parental guidance and support for her mother, the symptoms were allayed—for now.

The youngest victims of violence

The reactions of school-age and older children to violence are of enormous concern to families, teachers, police officers, and health care providers, and properly so. These reactions are relatively easy to understand, if challenging to treat. In their drawings, school-age children often reveal the violence that is part of their everyday lives and show their fear, sadness, or bleak resignation. School-age children can use language to express at least some of their concerns to people they trust. With education and support, adults can recognize children's aggressive or withdrawn behavior, or their dulled emotions, as symptoms of posttraumatic stress disorder.

Unfortunately, when babies, toddlers, and preschool children experience or witness violence, adults are much less prepared to identify and meet these children's need for psychological help. Many people, including parents, members of the law enforcement community, and journalists, think that infants and young children who witness violence are "too young to know what happened." They "don't take it in." They "won't remember." In fact, infants and young children can be overwhelmed by their exposure to violence, especially—as is likely to be the case with very young children—when both victims and perpetrators are well-known and emotionally important to the child and the violence occurs in or near the child's own home.

Jason and John, two-and-one-half-year-old twins, illustrate the importance of assessing and treating young victims of violence. When the twins were two years old, they saw their father shoot their mother in the face, killing her. The boys' maternal grandparents took over their care and coped as best they could for six months, while the boys fought continually with each other, woke up with nightmares, and generally made life miserable for the household. The grandparents recognized that Jason and John needed help and that they needed guidance in managing the boys' behavior and, even more important, helping them deal with the terrible trauma they had experienced.

We used a team approach to help the family. A child psychiatry resident working under the supervision of a senior child psychiatrist and a senior child psychologist engaged the boys in play therapy. Another psychologist counseled the grandparents concerning their own grief, loss, and trauma. Consulting regularly with the child psychiatrist, the psychologist offered the grandparents strategies to manage the boys' behavior at home and facilitate their recovery. The grandparents could call team members on the telephone as problems arose between treatment sessions, and for follow-up after treatment ended. The success of this approach was helped immeasurably by the grandparents' willingness to confront their own feelings of grief and loss, as well as by their ability to provide a safe and supportive environment for these little boys.

Factors influencing young children's responses to traumatic events

In evaluating and treating children exposed to trauma, it is important to understand factors that may lead to a more severe response to the trau-

matic event and those that may result in a less severe response for a child. The first factor is **intensity**. Witnessing someone pushing another person is likely to result in a less severe traumatic response than witnessing a shooting. A second factor is the child's **proximity** to the event. The research of Pynoos and others on sniper attacks in school yards (Pynoos, 1985) suggests that a child who is a first-hand witness to a violent event is likely to be much more strongly affected than a child who is shielded from full sight of the violence or only hears about the event. **Familiarity** with the victim, perpetrator, or both, strongly increases the intensity of a child's response to witnessing violence. From clinical reports and our work with police officers' and parents' perceptions of the effect of violence on children (Osofsky, 1996; Fick, Osofsky, & Lewis, 1996), we found that the involvement of a parent or someone very close to the child—as either the victim or perpetrator in a violent event—results in a much stronger impact on the child witness. The **developmental status** of the child will affect his or her response and capacity to cope with the impact of violence. While there is not much good evidence related to the effects of **chronicity** of exposure to violence, it is likely that experiencing violence repeatedly over the years may be devastating to the social and emotional development of young children, who learn, from what they see, that violence is a usual and acceptable way to respond to other people. It is not at all unusual to see a two-year-old who has been brought up in a violent home frequently hit his mother. In trying to understand the event, we learn that the child is imitating what he has seen his father or another adult male do to his mother. Chronic exposure to violence contributes to the dulling of affect and feeling observed in older children, many of whom say they feel little hope and do not expect to live beyond their teen years.

What factors protect young children from the most negative effects of exposure to violence? Factors that protect young children who have been exposed to violence are often the same factors that decrease the likelihood of people resorting to violence in the first place— that is, positive interactions and relationships with parents or caregivers; learning to relate to others in ways that are non-violent and involve negotiation and communication; access to positive role models, who may be a teacher, a teenager in the community, a police officer, a minister, or any adult or older person who demonstrates care for a child and models prosocial ways to relate. In addition to adequate housing, street lighting, and street police patrols, a high level of community involvement decreases the likelihood of violence in a neighborhood.

The contents of *Islands of Safety*

The essays in this publication draw on contributors' research, therapeutic work with very young children and families, and collaborative violence-prevention campaigns at the local and national level. Charles Zeanah and Michael Scheeringa describe the range of symptoms and behaviors typically shown by infants and young children who have been traumatized by their exposure to violence. Theodore Gaensbauer uses a detailed case example to illustrate the process of evaluating and treating persistent effects of a traumatic witnessing of violence. Marva Lewis presents a comprehensive approach to evaluating the caregiving environment of a traumatized young child, an approach that identifies sources of strength which can be mobilized and supported for the healing process. Betsy McAlister Groves explores the complex evaluation and treatment issues involved in work with young children and families affected by domestic violence, including the frequent tension between the needs of children and adults. Joy Osofsky describes what it is like for professionals to undertake and continue therapeutic work with young victims of violence; she offers guidelines for training and supporting front-line clinicians and for collaborating effectively with law enforcement officers and other community professionals. A consolidated list of references directs readers to much of the published literature in this new field; Margie Wagner reviews available videotapes for training and public awareness.

ZERO TO THREE: National Center for Infants, Toddlers, and Families invites readers of *Islands of Safety* to write to Emily Fenichel, Associate Director, with information about promising approaches to assessing and treating young victims of violence. We will make every effort to establish and strengthen connections between all who are engaged in this life-saving work.

Babies and toddlers who witness or experience violence may suffer severe lasting psychological harm. Prompt evaluation and treatment can substantially reduce damage to children's ongoing development.

Evaluation of Posttraumatic Symptomatology in Infants and Young Children Exposed to Violence

Charles H. Zeanah, M.D.
Michael Scheeringa, M.D.

Few of the thousands of infants and young children in this country who experience or witness violence in their homes or communities come to mental health professionals for evaluation and treatment. Why is this so? Several barriers seem to stand between traumatized young children and the help they need:

1. When babies and toddlers witness or experience violence, their primary caregivers are often witnesses to or victims of violence also. Coping with their own trauma (and often experiencing psychiatric symptoms), caregivers may be less capable than they usually would be of recognizing symptoms of distress in the baby and bringing these symptoms to professional attention.

2. Most people are not aware that infants and young children can develop psychiatric symptoms. Moreover, American culture generally dislikes the spectacle of people of any age who are in distress or grieving openly for long periods of time. Thus less-involved members of a child's extended family, friends, or community are likely to exert pressure on primary caregivers to "put the experience (of violence) behind them." People will assume that the best thing to do for very young children who have witnessed or experienced violence is just to forget about it—act as if nothing has happened and "move on."

3. A fatalistic attitude can also be a barrier to evaluation and treatment. Some parents and other adults will make the connection between a child's symptoms and his or her experience of violence, but they will see the symptoms as expectable, indeed inevitable, given what the child has been through. Even when the infant or toddler's extreme distress persists, caregivers with these attitudes may be unlikely to seek professional help.

4. Although parents and caregivers frequently bring young children to mental health professionals for evaluation and treatment of aggressive, disruptive, or "out-of-control" behavior, they may be unaware of how affected children may be from experiences of violence, particularly chronic domestic violence. If professionals do not ask specifically about possible experiences of trauma, posttraumatic symptomatology may not be recognized. It is important to find out if aggressive or oppositional behavior appeared only after a traumatic event and was not present before; if so, the diagnosis of traumatic stress disorder should be considered. Sometimes, of course, children who have an existing aggressive behavior problem experience trauma. With these children, sorting out what came after and what predated a traumatic event may be difficult. Perhaps the most important thing to remember when evaluating a child in the second or third year of life who is exhibiting a great deal of aggression or opposi-

Charles H. Zeanah, M.D.
Division of Infant, Child and Adolescent Psychiatry
Louisiana State University School of Medicine
New Orleans, Louisiana 70112

Michael Scheeringa, M.D.
Kennedy Krieger Institute
Johns Hopkins School of Medicine
Baltimore, Maryland 21205

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Traumatic Stress Disorder

In *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)*, published by ZERO TO THREE in 1994, Traumatic Stress Disorder is among the primary diagnoses described.

According to *DC:0-3*, Traumatic Stress Disorder describes a continuum of symptoms which may be shown by children who have experienced a single event, a series of connected traumatic events, or chronic, enduring stress. These might include an infant or toddler's direct experience, witnessing, or confrontation with an event or events that involve actual or threatened death or serious injury to the child or others, or a threat to the psychological or physical integrity of the child or others. The traumatic event may be a sudden and unexpected event (e.g., earthquake, terrorist attack, mauling by an animal); a series of connected events (e.g., repeated air raids); or a chronic, enduring situation (e.g., chronic battering or sexual abuse).

The nature of the child's symptoms must be understood in the context of the trauma, the child's own personality characteristics, and his or her caregivers' ability to help the child cope, in terms of a sense of protection and safety, as well as working through the experience. In some cases, the memories children report may change as part of their attempts to rework the trauma. Thus, change in a young child's account of the trauma does not necessarily indicate that the trauma was simply a fantasy.

Especially with severe trauma, like life-threatening injury to a family member, it is important to make the diagnosis and begin working with the child and family immediately. In most circumstances, without effective intervention, traumatic stress reactions will persist.

from ZERO TO THREE, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)*,1994, p. 19.

tional behavior is to ask specifically about the child's experience of trauma or violence—including witnessing chronic domestic violence.

Before we can help traumatized young children in significant numbers, we need to reach parents and the general public with two key messages: First, babies and toddlers who witness or experience domestic or community violence may suffer severe, lasting psychological harm. Second, prompt evaluation, counseling of families, and treatment of traumatized young children can substantially reduce damage to their ongoing development.

Symptoms of traumatic stress disorder in infants and young children

Infants and toddlers who have been traumatized experience the same three types of symptoms that older children and adults experience—that is, re-experiencing the traumatic event in various ways; numbing of responsiveness and avoidance of reminders of the traumatic experience; and various manifestations of hyperarousal. These are the three hallmarks of traumatic stress disorder across the lifespan, but symptoms manifest themselves in different ways in young children than they do in older children or adults. In addition, very young children who have been traumatized develop two other kinds of symptoms: development of new fears that were not present before the trauma and the development of aggressive behavior that was not present before the trauma (ZERO TO THREE, 1994; Scheeringa, Zeanah, Drell & Larrieu, 1995).

Re-experiencing symptomatology

Lenore Terr (1990) described *posttraumatic play*, a distinctive way in which young children play out aspects of the trauma they have experienced. Posttraumatic play is repetitive and monotonous, and the child may exhibit a dazed or trance-like appearance. The child's affect tends to be somewhat blunted. The most remarkable characteristic of the play is its unchanging, "stuck" quality—the child repeats the same play sequence, over and over and over again. Post-traumatic play has been identified in children as young as 22 months; any child capable of some pretend play may express symptoms through posttraumatic play.

Janine was 19 months old when she witnessed her mother being assaulted and raped by an acquaintance. After Janine's mother fought with

the man for several minutes, he grabbed Janine and held a gun to her head in order to get her mother to do what he said. Janine was not physically injured during the attack, although she was present throughout.

In addition to a number of other symptoms, in the weeks following the rape, Janine developed a repetitive sequence of play in which she threw dolls down on the floor and hit them. She tended to repeat this over and over without elaboration and without obvious affect, according to her mother. She did not demonstrate this play in the examining office during the evaluation but only at home with her mother. The play dissipated gradually during her first several weeks of treatment.

Re-enactment play is a more common manifestation of trauma in young children. Here, the child again plays out some aspect of the trauma, but the play is changing and moving. Re-enactment play suggests that the child is actively working on the traumatic experience; this play is believed to be more adaptive than posttraumatic play.

Larry is 40 months old. Almost a year ago, when he was 29 months old, Larry saw his father shoot himself, fatally, in the head. Now, Larry's mother has brought him to an infant mental health clinic because Larry won't stop talking about his father shooting himself.

During the initial evaluation session with his mother and a male examiner, Larry picks up a toy gun that is in the playroom, examines the trigger, walks over to the examiner and shoots him in the head, saying, "I'll shoot you!" Then Larry says, "I'll shoot Mommy!" He walks over to his mother and shoots her in the head. Later in the session, he picks up a daddy doll, shoots it in the head with the gun, and he says, "He is dead." Then he shoots the mother doll in the head.

This was a difficult session, even for the clinician conducting it. He checked repeatedly with Larry's mother to make sure she was all right. Although it is not unheard of for young children to "shoot" their clinicians in play, Larry was quite preoccupied with shooting in the head. The repeated and insistent shooting of adults and doll figures in the head suggests that it is likely to be a result of what Larry experienced with his father.

Nightmares are one of the hallmark symptoms of traumatic stress disorder, and a symptom possibly more common in children than in adults, who are more likely to experience visual flashbacks while awake. Although the content of very young children's nightmares may be difficult to ascertain, the symptom itself is important. Even if the content of a child's nightmares cannot be ascertained, we consider nightmares to be posttraumatic symptomatology as long as they begin after the child has experienced a traumatic event.

Dissociative reactions in young children who have experienced trauma are not yet well understood. At the mild end of a continuum of dissociative phenomena are behaviors such as those described by attachment researchers as "disorganized," including dazed expressions and stereotypic behaviors (Main and Solomon, 1990). Intermediate on the continuum are episodes of extreme withdrawal, exhibited by some young children when the topic of the trauma comes up, and episodes of periodic unresponsiveness. At the more extreme end of the continuum are actual experiences of altered states of consciousness.

Alexandra is a 19-month-old girl who has been raised continuously by both her parents. She has been referred to us for evaluation by child protective services because of significant developmental delays and her lack of discernible attachment to anyone. This pattern of nonattachment, unusual in a child who has been in neither an institution nor multiple foster homes, suggests severe and chronic neglect during her early life.

In the evaluation, Alexandra is administered a Bayley exam. At one point the examiner presents her with red cubes and asks that she make a tower. Alexandra is more interested in playing with the blocks than in making a tower. She becomes frustrated at the examiner's insistence, and suddenly she becomes completely unresponsive. She stares blankly straight ahead, not only failing to respond to the examiner's eye contact, but also failing to respond to the examiner's voice or touch. The episode lasts for 15 seconds. Afterwards, Alexandra resumes eye contact, but it is another two minutes before she becomes as responsive as she had been previously.

These episodes were observed on a number of occasions by Alexandra's child care providers. Concerned about a possible seizure disorder, we ordered an EEG, which was normal. As intervention with Alexandra proceeded, the episodes of unresponsiveness disappeared, leading us to believe that they were more likely to be dissociative reactions rather than manifestations of a seizure disorder.

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Numbing of responsiveness

Very young children show numbing of responsiveness by becoming emotionally subdued, socially withdrawn, and/or more constricted in their play. Associated with numbing and avoidance are the loss of recently acquired developmental skills (such as toileting skills). Regression in expressive language is very common. Some children show generally subdued affect and constriction of activities and interests. Others may exhibit discrete episodes of emotional and social withdrawal; these episodes may or may not have obvious precipitants.

Stephen is a 22-month-old boy who was referred for evaluation by his paternal grandmother after he witnessed his mother shoot and kill his father. Stephen was sleeping in his father's arms at the time of the shooting and afterwards was taken to a neighbor's house, still in blood-soaked pajamas. The following day his mother shot herself and died.

For several months following this event, Stephen had discrete episodes of extreme withdrawal in response to any mention of his parents. During these episodes, which lasted for 10 to 30 minutes, he was never completely unresponsive, although he was difficult to engage. He did not exhibit these episodes in any context other than following mention of his parents.

Avoidance

Because of their cognitive and motor immaturity, infants and young children have limited capacities to avoid reminders of traumatic events. Nevertheless, to the extent that they are able, they may attempt to avoid such reminders. For example, an infant who has been abused by a man with a beard may demonstrate a phobic avoidance of bearded men.

Hyperarousal

In infants, hyperarousal may take the form of increased irritability, emotional lability, temper tantrums that were not present before the trauma, increased night awakening, decreased concentration, and hypervigilance. Exaggerated startle responses are not uncommon. Other than tantrums and sleep disturbances, many of the other manifestations of hyperarousal in infants and young children must be specifically queried, as they are not commonly complained about by caregivers.

Janice is a 30-month-old girl who was referred for evaluation by hospital personnel after seeing her mother being badly beaten (leading to mother's hospitalization) by her boyfriend. Janice's sleep was quite disturbed following this episode. Although she would fall asleep without protest, she cried out 3 to 4 times per night, unresponsive and inconsolable until she fell back asleep again. She also woke up screaming for her mother or for her mother's assailant to leave her alone. At these times, she could be comforted by her grandmother and later by her mother when she returned home from the hospital. She also exhibited a tendency to startle in response to loud voices or even noises.

Fears and aggression

Young children often develop a variety of new fears following a traumatic event — especially fear of the dark, fear of toileting alone, fear of separation from primary caregivers, and exaggerated fear of strangers. Not uncommonly, toddlers may suddenly be afraid to try activities that they had mastered prior to the traumatic event.

Aggression may be directed toward the self or toward others, and it is not uncommon for a child to show both forms—for example, head-banging and/or scratching the face, coupled with attacks on others. Aggression towards others may be directed at peers, at siblings or at caregiving adults.

The process of assessment

Assessment of an infant or young child who is brought to professional attention because of a known experience of violence should include, first of all, a very detailed history of the trauma. When a child has been traumatized or when presenting symptoms (such as extremely aggressive or oppositional behavior) suggest that trauma may have occurred, it is important to ask about all potential traumas that the child may have experienced, including, in particular, witnessing violence between parents or between a primary caregiver and partner.

To understand what the baby or young child's adaptation was like before the trauma, a good developmental history is important. A contextual history will describe current circumstances for the child and entire family, including sources of support and sources of stress for the child's caregivers. The child should be observed in interaction with both a familiar caregiver and the clinician, so that one can get a sense of what the child is like with familiar and non-familiar people. As

the child is observed in play, it may be useful to attempt to structure the play in a way that may elicit some response to the traumatic experience.

In evaluating a baby or young child who has been traumatized, paying attention to the caregiver is critical. Virtually all of the studies that have looked at parent factors in child symptomatology in traumatic stress disorder have found significant relationships (e.g., Carey-Treizer, 1949; Famularo, Fenton, Kinscherff, Ayoub & Barnum, 1994). Parent factors that seem most closely related to symptomatology in children are: 1) mothers' and fathers' own symptoms of posttraumatic stress disorder; 2) levels of general parental psychopathology; 3) the presence and/or extent of denial concerning the child's symptomatology; and 4) changes in family functioning that may have a powerful indirect effect on the baby's functioning and development.

It is extremely important to ask specifically about the degree to which a threat to the child's caregiver was part of the traumatic experience. We have looked at a number of different characteristics of both the baby and the trauma to try to determine which were related to the severity of the child's symptomatology. The best single predictor of the severity of infant symptomatology by far was whether or not the caregiver was threatened by the traumatic event (Scheeringa and Zeanah, 1995). Fewer numbing symptoms, more hyperarousal symptoms, and more new fears and aggression occurred in cases in which the caregiver had been seriously threatened in the traumatic event. Threat to the caregiver was more predictive of symptomatology than injury to the child himself or herself.

In addition to considering the parent factors listed above, one should also assess the quality of the relationship between a child who is being evaluated for traumatic stress disorder and his or her primary caregivers. Relationship assessment is important for several reasons, even though traumatic stress disorder may be the mental health diagnosis most likely to be called a "within-the-individual" disorder of infancy. First, the relationship between a very young child and his or her main caregivers is the most important context for infant development; as the relationship with the caregiver goes, so goes the baby. Second, changes in routine can have powerful effects on the baby, and if the caregiver is very affected by a traumatic experience, this may lead to dramatic changes in routine that have profound effects on the baby and the baby's day-to-day functioning. Third, an assessment of the relationship highlights the ways in which a caregiver's own symptomatology may limit or interfere with his or her ability to help the child work through a traumatic experience. If you are very distressed yourself, it is hard to care for someone else, particularly someone who is very distressed. Consider, in particular, the issue of avoidance and play re-enactments of trauma. As noted above, avoidance of any reminders of trauma is a hallmark of traumatic stress disorder in both children and adults. How painful it is then, for many caregivers to observe the play re-enactments that occur in our assessment process. In the case of Larry, described above, the boy's affect was almost gleeful as he "shot" the examiner and his grief-stricken mother; the mother must have found this enormously distressing. Understanding the quality of the relationship between a child and his or her primary caregivers both before and after the traumatic event is key to decision making about treatment.

Children who experience traumatic events can reawaken or stir up traumatic experiences from the caregiver's own past. This phenomenon must be considered in the context of assessment.

Rashad's mother has become preoccupied with her child's experience of trauma, and she has brought him to the clinic for evaluation. She asserts that her 44-month old son is preoccupied with sexual abuse by older boys some 6 to 12 months previously. In free play, the mother introduces dolls to the little boy and gives them the names of the older boys who allegedly abused Rashad. In response, Rashad begins to stutter and stammer. Then the mother assigns parts in the play, telling her son to play himself and the two older boys, while she takes the parts of herself and the boy's father. The child protests, saying he wants to be "the biggest boy." He is getting anxious, and it is hard for him to distinguish reality from fantasy. The mother continues to "push" the play (and her own agenda), never following the child's lead.

When we saw Rashad alone, there was no evidence that he was preoccupied by the alleged traumatic event. Rather, the mother's concern seemed connected to her own history of sexual abuse. It would not have been appropriate to interrupt the session described above, which took place early in the assessment process. We

recognized, however, that after building an adequate therapeutic alliance with Rashad's mother we would need to focus on her experience.

From evaluation to treatment

In order to guide intervention planning appropriately, an evaluation of a traumatized infant or young child should address the following issues (Zeanah, 1994):

1. The safety and stability of the current living situation: It is hard for anyone, of any age, who has been traumatized to benefit from treatment if he or she is not living in a reasonably safe and stable environment.

2. The age and developmental level of the child before and after the trauma in order to appreciate the infant's perceptions of the trauma and to appreciate the developmental issues likely impacted by the traumatic event.

3. The quality of the pre-traumatic caregiving environment and the likely impact of the traumatic event or circumstance on that environment.

4. The nature of the traumatic event or circumstance: Was the trauma acute or chronic, a single episode of witnessing a violent event or ongoing abuse?

5. The child's actual and psychological proximity to the violent events, especially if a threat to an important caregiver occurred.

6. The child's symptom picture, especially posttraumatic symptoms that appeared after the event.

7. Strengths and protective factors, especially relationships that may help the young child work through these experiences.

Not all of the symptoms and responses of infants and young children who have been traumatized reflect posttraumatic symptomatology. We believe that it is a mistake to consider that every infant or young child who has experienced a trauma has posttraumatic stress disorder (PTSD). Some traumatized infants and young children may be free of symptoms; others may manifest other forms of psychopathology. It will be important for our understanding of trauma and posttraumatic responses to limit a diagnosis of PTSD to those situations in which: 1) the specific symptom clusters are identifiable following a traumatic event; and 2) symptoms were not present before the traumatic event or, at a minimum, became qualitatively different following the traumatic event.

We are still at an early stage in our understanding of the evaluation and treatment of posttraumatic symptomatology in infants and young children. We have much to learn from children, families, and colleagues. At this point, it seems wisest for clinicians to describe as carefully as possible all posttraumatic and other symptomatology in infants and young children and to note their temporal relationships to any obviously traumatic events. At this early stage there is clearly much that remains to be learned. Research findings must inform and update clinical practice even as clinical practice focuses and enriches research questions.

Islands of safety are crucial for children because they provide the conditions under which development can proceed.

Developmental and Therapeutic Aspects of Treating Infants and Toddlers Who Have Witnessed Violence

Theodore Gaensbauer, M.D.

Trauma occurring early in life, particularly if severe, can have enduring developmental consequences. Fortunately, we are learning more and more about specific therapeutic approaches which can help to reduce the impact of such early trauma. Perhaps the most compelling way to illustrate the devastating long-term effects of trauma, and to examine the usefulness of particular therapeutic approaches is through the detailed presentation of an individual child. Although my contact with Kevin and his family (names and identifying details have been changed to preserve confidentiality) was for the purpose of evaluation, I believe that our meetings helped reduce the intensity of his response to the trauma he had suffered and suggested ways that Kevin could be helped in the future.

Kevin and his family: Background history and symptomatology

Kevin was two-and-one-half years old when he, his mother, and fifteen-year-old half-sister were waiting in their car while his father went into a local convenience store late one evening to buy some bread. While in the store, his father became involved in an argument with two men, leading to a physical fight. The men pulled a knife, chased Kevin's father around the store, and stabbed him repeatedly. The family witnessed the entire confrontation in a state of panic. Kevin cried hysterically, "They're hurting my daddy" while his mother and sister attempted to seek help. The father died of his wounds shortly afterwards.

Kevin was referred to me for a forensic evaluation two years later, when he was four-and-one-half. I had the opportunity to review his medical records, interview his mother, and carry out three sessions with Kevin.

Immediately following his father's death, Kevin had shown characteristic symptoms of posttraumatic stress disorder (PTSD) (Scheeringa et al., 1994). He had great difficulty sleeping, with many frightened awakenings, though he had not described any specific dreams at that time. Two years later he was still afraid to go to sleep and would stay up until early morning, a pattern he shared with his mother and half-sister, who were also continuing to experience significant PTSD symptoms. Kevin demonstrated persisting reenactment play involving stabbing actions and threats with a knife, both with doll figures and in fights with siblings and peers. His play with dolls was prototypical "posttraumatic play" (Terr, 1983) involving repetitive, almost obsessive physical fighting between "good guys" and "bad guys." In contrast to most four-year-olds' stories, the good guys in Kevin's scenarios often got killed. At times Kevin would make a connection between the play and the trauma, saying his daddy was a good guy and the bad guys were like the ones who hurt his daddy.

Since his father's murder, Kevin had also shown a marked increase in aggressive behavior and angry outbursts: tearing up toys, hitting other

Theodore Gaensbauer, M.D.
935 East Exposition Avenue
Denver, Colorado 80209

children, and acting defiantly toward his mother and other caregivers. At the time of my evaluation, he was still trying to understand and accept the loss of his father. He would periodically ask his mother if his father was ever coming back or would make spontaneous comments such as "All we went for is bread, huh, Mommy?," as if he had not accepted his father's loss nor fully assimilated what had occurred. He had also expressed wishes to die and join his father in heaven, and on one occasion had stabbed himself in the nose with a fork, to the point of drawing blood.

Other typical PTSD symptoms included marked separation fears, particularly with his mother, startle reactions, a significantly reduced attention span, periods of hyperactivity and restlessness during which he seemed to be "bouncing off the walls," and language regression. Toilet training had also been disrupted. He had not achieved day-time bowel and bladder control until five months prior to my evaluation, and was continuing to show occasional wetting. His mother also described a marked personality change in the direction of sadness and withdrawal, in contrast to his previous happy, outgoing nature—"the sparkle is gone" was the way she put it.

Interviews with Kevin

In my interviews, Kevin appeared as an engaging child who was capable of moments of enthusiasm and happiness and seemed to have age-appropriate developmental skills. At the same time, it was evident that the traumatic experience remained a preoccupying, centrally disturbing element in his psychic life, more than two years after the event.

At our first meeting, as I greeted him in the waiting room Kevin smiled happily and engaged me in conversation. However, as he approached he abruptly hit me in the leg. When I asked him why he hit me, he said it was because he thought I would hit him back. He then said that I didn't even know him and that he was afraid I didn't like him. The idea seemed to be that he felt physically at risk in meeting a man whom he didn't know and that he had hit me in a kind of preemptive strike.

When he entered the playroom, Kevin almost immediately found some GI Joe figures and began to play out physical fights, with the characters using swords instead of guns. As he was playing, he brought up the issue of "dads" in an indirect way, telling me his half-sister had two dads. This opened the door for me to ask him about his family and how many dads he had. While initially hesitant, he said he would tell me a story about his dad and that his dad was dead. He told me his father's name, but then said that was all he was going to say. He got a toy gun and told me I was under arrest, but then he became the bad guy, stealing my money and then shooting me.

Shortly after this play, he became anxious and wanted to return to the waiting room to find his mother. She had told us prior to our going into my office that she was going to run a quick errand. Unfortunately, when we returned to the waiting room, she wasn't there. Kevin's anxiety quickly escalated. He refused my attempts at reassurance, and did not want to return to the playroom to wait. Instead, he went out the main door to my suite and began desperately trying to open doors to other offices on the corridor, searching for his mother. He became increasingly distraught, to the point that I even proposed going to the parking lot where we could meet his mother as soon as she returned. He asked several times what store his mother had gone to, and finally said "what if she went to ___!", and specifically named the store at which his father had been killed. He said, "I don't want her to go there," and when I asked him to elaborate, he said, "Someone could kill my mom!" He clearly was continuing to live with the very immediate fear of losing his mother in the same way that he had lost his father.

In our next session, Kevin's mother again did not remain with him, but left him with his half-sister, whom I was also seeing in evaluation. As in the first session, Kevin initially came into the playroom happily and resumed his play with the GI Joe figures. Since he seemed quite comfortable, I asked him at one point about his scared feelings from last time. He again told me he had been afraid that his mom would be killed. Almost immediately, he asked to leave the room to get his half-sister. With his half-sister present, he was able to share that he worried about his mother because of what had happened to his father, and to demonstrate very accurately how his father was stabbed. He described feeling very sad, said that he still thought about the stabbing a lot, and, after falling silent, nodded in a very poignant way when I asked him if it was hard to talk about. Though he was able to talk and to accept empathy from his half-sister and me, he was clearly under a great deal of tension, wringing his hands and making physical contact with his half-sister.

At one point, his sister commented about Kevin's difficulties sleeping by himself. Kevin agreed, saying he was scared of the dark and of scary movies. His sister observed that Kevin was also very scared of someone coming to get him. I wondered if Kevin worried about something happening to him like what happened to his dad. This interpretation was too much. Kevin paused, then asked in an angry way, "Why do I have to answer these questions?" I thought it a sign of strength that even in the midst of his anger, he was able to say that the reason he did not want to talk was because it made him afraid. His irritated response led into a discussion not only of his anger at me for asking so many questions, but also his angry feelings at home and at the bad guys who killed his father. He was, however, clearly at the edge of what he could handle, and soon after began to act more wildly and provocatively, climbing on the furniture and playing with items on my desk. We suspended further attempts to talk about his father, and eventually, Kevin fell asleep while I carried out an interview with his sister.

In our third session, Kevin was calmer and able to remain for the whole session. He again chose to play with the GI Joe figures. He had me hold a somewhat larger robot toy, as he knocked the robot over several times with the figure he was holding. He then abruptly seemed to become anxious, saying "I don't want to play this any more" and wanted me to put the robot away. My thought was that the process of dealing so directly with his father's loss in our sessions had caused a psychological shift. What had previously been emotionally blunted and unproductively repetitive posttraumatic play had become more therapeutically workable, affectively loaded reenactment play. Kevin's feelings had come closer to the surface.

Later in the session, Kevin acknowledged directly that he liked to play rather than talk because talking made him think about what happened to his father. He said he thought about his father most when he went to bed and that he was scared to go to sleep because he didn't like to be in the dark (his father was killed at night) and because he had bad dreams. When I asked if he could describe a bad dream, he said he had dreams about a movie he saw about clowns who had big, sharp teeth and killed people with them. While ostensibly related to a horror movie he had actually seen, the image had obvious associative links to his father's death. He answered yes when I asked if he had bad dreams about what happened to his dad and also nodded when I asked if he thought a lot about his dad during the day, too.

I mentioned that his mother had told me that he missed his dad so much that he thought about going to heaven. He immediately responded, "I could kill myself." When I asked him how he said, "Easy. With a knife." A last observation, made toward the end of the session, related to Kevin's difficulties with other children. He said they made him nervous and so he hit them, a similar reason to the one he had given for hitting me in the first session.

Compounding his difficulties, Kevin's mother experienced severe posttraumatic and depressive symptoms herself and had not been able to consistently meet his emotional or physical needs, as exemplified by her unavailability during my first two interviews. Kevin thus not only lost his father, but in many respects lost his mother and any semblance of family stability as well. This no doubt contributed to the overriding preoccupation with his father's death shown by the entire family which had persisted despite extensive therapy for all of them in the interval between the trauma and the time I saw them.

Discussion: The impact of trauma on development

My interviews with Kevin provide a framework for a number of points concerning the impact of trauma on children's development. The first relates to the various aspects of development which are potentially influenced by a trauma. (For a detailed examination of the developmental consequences of trauma, the reader is referred to the excellent review by Pynoos, Steinberg and Wraith [1995]). As a way of organizing my own clinical thinking, I have conceptualized seven different levels of potential developmental impact (Gaensbauer, 1994). I utilize these various levels of impact as a framework for thinking about therapeutic goals, with the thought that in an ideal therapy each of these areas will need to be addressed if the child is to regain his or her pretrauma level of functioning. Kevin demonstrates significant impact in all but one of these possible levels.

1. The first and most immediate level involves characteristic posttraumatic symptoms such as reexperiencing, avoidance of reminders, numbing

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of general responsiveness, and increased arousal, which are seen across a wide variety of traumas and which likely have a strong biological basis. All of these were seen in Kevin.

2. A second level relates to the associated feelings and psychological meanings connected to the particular circumstances of the trauma, such as depression, feelings of responsibility or guilt, or the search for omens, reflected, for example, in Kevin's repeated questions about why it was the family had gone to the convenience store in the first place.

3. A third level concerns disruption in developmental issues being worked on at the time that the trauma took place, for example, in Kevin's case issues of separation and independence, the modulation of anger and aggression, and toilet training.

4. A fourth level concerns disruption in subsequent developmental phases, as seen in the continuing dominance of posttraumatic symptoms and themes two years after the event, interfering with typical four-year-old developmental issues related to bodily integrity, gender identification (Kevin's identification with his father and his continuing grief were contributing to self-destructive impulses), and conscience development (evidenced in his confusion about whether to be the good guy or the bad guy in his role playing). It was also undermining his readiness to undertake activities outside the nuclear family, including school and peer relationships.

5. A fifth level involves effects of the child's symptoms and behavior on interactions with others. Kevin's perseverative reenactment play, his anxiety, his self-destructive behavior, and increased aggression had all placed great strains on his caregivers and playmates.

6. Sixth, there is the independent impact of a trauma on other family members, independent of the child's reactions. In this instance, Kevin's half-sister and mother witnessed the same trauma and experienced their own PTSD reactions. Even when parents or other family members have not been witnesses, their reactions can be intense and long-lasting, and influence their subsequent treatment of the child (Green and Solnit, 1964).

7. A seventh level, thankfully not as significant a concern in infants and toddlers and not an issue in Kevin's case, is the extent to which a trauma may bring up memories and feelings related to previous traumas.

Kevin's continuing preoccupation with the trauma, reflected in recurrent, affectively intense reexperiencing of the traumatic events, illustrates what I believe is a crucial mechanism in producing the kinds of distortions in developmental processes described above. Traumatic memories are, as Lenore Terr (1988) has described, powerfully imprinted on the child's psyche. These memories, however, are not represented by static photographic-type images, but rather appear as fluid mental representations characterized by multiple sensory modalities, intense affective reactions, and a sense of temporal sequence. I believe that although they may not know how to interpret it, even infants and toddlers have the capacity to carry this "movie" inside their heads, with repetitive "showings" being triggered either by internal or external cues (Gaensbauer, 1995). The movie, moreover, is not a set of actions seen on some internal screen, separate from the child's consciousness. Rather, the child experiences it as happening "now!" with all the associated perceptual, affective, and behavioral accompaniments. An example of such everyday reexperiencing would be Kevin's description that his playmates made him "nervous," so he hit them. Their proximity was perceived as threatening, elicited a sense of danger, and resulted in a defensive counterattack, all outside his awareness.

These enduring sensory-motor/affective representations and their "here and now" immediacy are thus not just disorganizing in nature, but instead come to play an organizing role in the child's development, coloring and distorting many subsequent experiences. The younger the child, the greater the risk that such reexperiencing will become integrated into the child's core identity rather than be experienced as a set of memories and feelings which is alien to the pre-trauma sense of self. For example, a 12-month-old girl who observed her mother gruesomely killed by a letter bomb appeared to be plagued by images of the scene, manifested by her drawings, dreams, and symptomatic reactions, accompanied by feelings of wildness and aggression. By age six, these representations and their affective accompaniments had became so intertwined with her identity that she was showing signs of a significant disjuncture in her sense of self—there was the "good Audrey," who was loving and happy, and the "bad Audrey," who was plagued with violent imagery and sadistic impulses (Gaensbauer, 1995).

The extent to which a trauma will be organizing in this distorting way will be dependent on many factors, including the severity of the trauma, the intensity of the traumatic affects, the degree of permanent loss or disability, the child's pre-trauma adjustment, and the quality of environmental support. The frequency of such affective reliving will also depend on the frequency of exposure to cues likely to trigger traumatic memories, with a trauma that is relatively isolated from the child's everyday experiences likely having a lesser impact. For example, if a trauma has occurred during a boat ride and the child in the course of everyday life is not exposed to water, one might hypothesize a lesser impact than when a trauma has occurred in a more everyday setting. I mention this because it highlights what I believe is an important contribution to the tremendously destructive impact of community and family violence on children. There is no place of safety if the child is flooded with reminders every day, or even every hour, of his or her life. If your father can be killed while doing something as simple as running a brief errand to a convenience store, how can you assume that any activity outside the home is safe? With family violence, not even the home is safe (Groves et al., 1993).

Islands of safety are so crucial for children because they provide the conditions under which development can proceed. A two-year-old child, involved in an auto accident in which a parent was killed, would become fearful that something terrible was again going to happen in a variety of everyday situations. Remarkably, however, he seemed able to participate happily with peers in his child care setting without having the anxiety triggered. The child care situation seemed to be an island of unencumbered tranquility where he was able to play enthusiastically and to grow. Kevin, unfortunately, experienced the worst of possible worlds. Though able to show moments of happiness and spontaneous play, such as those seen in his initial interactions with me, which reflected underlying strengths related to his previous happy adjustment, in his current environment he was awash with traumatic reminders. Given the catastrophic disruption in his family functioning, he experienced few moments of safety where his underlying strengths could be nurtured.

Guiding principles for psychotherapeutic treatment

Given the severity of his trauma and the many levels of disturbance, the therapeutic challenge for Kevin and children like him is immense. As a guiding principle for psychotherapeutic treatment, I find Robert Pynoos' summary statement to be most apt—namely to help the patient re-experience the trauma and its meaning in affectively tolerable doses in the context of a safe environment, so that the overwhelming traumatic feelings can be mastered and adaptively integrated into the person's emotional life (Pynoos, 1990). Though obviously a narrow window for observing a therapeutic process and colored by the fact that their purpose was evaluation rather than therapy, the sessions with Kevin suggest how this principle might work in practice. I would like to briefly review the three sessions, highlighting certain therapeutic aspects.

In the first session, Kevin's posttraumatic play and his sharing of the information that his father was dead elicited anxiety and a desire for contact with his mother. In turn, her absence exacerbated in a very immediate way his anxious memories about his father and fears about losing her. While at the most immediate level the episode elicited strong efforts on my part to relieve his anxiety, it can also be seen as an opportunity for therapeutic reworking. It allowed me to observe and reflect back to him the intensity and persisting nature of his fears, and to help him separate the traumatic reliving from the current situation. I found it a sign of emotional strength that he was able to articulate his fear very clearly, thus enabling me to provide direct empathic support. Each such episode of emotional reliving, as it occurs, represents an opportunity to desensitize the intensity of the child's affect and enhance the child's awareness that his or her reactions are being driven by traumatic memories. In such contexts, I believe, general comforting and nurturance is not enough. It is important to make the connection for the child to the previous trauma ("You are scared because you are remembering what happened to your father"). If this connection is not made, the episode runs the risk of being experienced by the child as traumatizing—one more scary experience that he or she was lucky to get through—rather than being seen as an overdetermined response driven by internal forces.

In the second session, with his sister's support,

Kevin was able to share more about what had happened to his father, including demonstrating the actual attack. In this session, emotions initially coming to the fore were fear and sadness, followed by feelings of disorganization and anger when the sad feelings became overwhelming. The sequence enabled me to make the connection between his painful feelings of loss and his feelings of anger. Although the anger no doubt had many determinants which would need to be explored, a crucial element in the therapy of trauma is to help both child and parents to recognize when the child's aggression is related to traumatic experience, rather than to character faults or a developmental phase. The increased aggression and hyperactivity characteristically seen in posttraumatic reactions is very difficult for parents to deal with, and can often lead to destructive interactive patterns. Indeed, Kevin's sister became irritated with him in the session, which only increased Kevin's defiance.

This session with his sister also highlighted some of the benefits to carrying out therapeutic sessions with parents or other family members present, if they can handle it. As did Kevin's sister, parents can provide support that facilitates the child's emotional reworking and helps rebuild the child's sense of trust. The parents' presence will bring about many opportunities for the therapist to promote understanding of the child's reactions and reduce negative interactional cycles. For example, when his sister became irritated about Kevin's misbehavior, I pointed out the sequence leading to Kevin's anger, in an effort to increase the sister's tolerance. Parents can provide information about the child's symptoms at home, as Kevin's sister did in bringing up Kevin's fears and sleeping difficulties. They can also provide crucial information about how reenactment play in the office may be related to the traumatic experience, particularly with young children. For example, a three-year-old boy who had experienced a series of painful medical procedures when he was fifteen months of age placed a boy doll in a hospital bed and then aligned a toy crutch next to the boy's leg. While I did not appreciate the significance of this action, his mother told me that after one of his procedures he had had a splint extending down the side of his leg to protect an IV site (Gaensbauer, in press).

By the third session, despite the difficult emotional moments of the previous two sessions, Kevin seemed to have developed increased comfort in my office. He was able to allow feelings of anxiety associated with his reenactment play to come to the surface without having to leave the room. As in each of the first two sessions, he provided further details about reactions we had previously explored, such as his bad dreams, and introduced new themes, such as his problems with peers and the loss-driven identification with his father leading to impulses to stab himself.

In the course of these three sessions, one can catch a glimpse—the tip of the iceberg, really—of the variety and complexity of Kevin's affective reactions to his tragic loss, and the ways these reactions can be manifested in a therapeutic setting. The crucial factor in the development of a therapeutic process is, in my opinion, the extent to which the traumatic affects can be identified and brought to the surface in a manageable way. In my questioning, I took Kevin to the edge of what he was able to tolerate. On a couple of occasions I unfortunately went over. I was certainly attempting to stay within the bounds of the manageable and believe from the evolution of the material that on balance I succeeded. Kevin's reactions certainly raise the question of therapeutic tact, and how active the therapist should be in focusing the child's attention on trauma issues. Kevin's situation was clouded by the fact that I was doing a forensic evaluation and needed to get information in a short period of time. These circumstances notwithstanding, I often tend to be active in attempting to elicit the child's reactions, since children are at times not able to carry out this necessary work on their own. This can be done through verbal communication or through reenactment play, both of which were relevant in Kevin's case. With younger children especially, I will often use structured situations which recreate the situational context in which the trauma occurred (Levy, 1939) and then encourage the child to play out "what happens next" as a way of helping children to express their memories and develop a more coherent narrative regarding the traumatic events (Gaensbauer and Siegel, 1995).

Though evaluative in nature, I believe that my meetings with Kevin contributed in some small measure to reducing the intensity of his traumatic affects, through the opportunity to share his tragedy. I believe that this sharing, a bit at a time, is ultimately the most important thing we have to offer.

Our goal is to understand the strengths and vulnerabilities of the caregiving environment so that we can begin the work of supporting caregivers and healing traumatized young children.

Trauma Reverberates: Psychosocial Evaluation of the Caregiving Environment of Young Children Exposed to Violence and Traumatic Loss

Marva L. Lewis, Ph.D.

When a baby or young child experiences or witnesses violence, trauma reverberates throughout the caregiving environment of that child. The child's caregiving environment includes not only biological parents, but also extended family and the neighborhood. The impact of trauma is especially powerful when an infant or toddler loses his or her parent or primary caregiver through violent death (Bowlby, 1980; Gertzel & Master, 1984; Terr, 1990). This paper presents a protocol for conducting psychosocial assessments of caregivers and families in which young children have been exposed to violence and trauma. Our goal is to understand the strengths and vulnerabilities of the caregiving environment, so that we can begin the work of supporting caregivers and healing traumatized young children.

The protocol presented here was developed at the Department of Psychiatry, Louisiana State University Medical Center for the Violence Intervention Project for Children and Families (Osofsky, Lewis, & Fick, 1994). Conceptually, the protocol is grounded in an ecological/transactional approach to child development and violence (Bronfenbrenner, 1979; Cicchetti, & Lynch, 1993); attachment theory, particularly with respect to maternal sensitivity and very young children's responses to death, separation and loss (Bowlby, 1980); and family systems theory related to concepts of family structure and the family developmental life cycle (Minuchin, 1984).

The protocol, an assessment designed to facilitate interventions with the caregiving environment, continues to evolve. It grew out of initial work with grandparents and other extended family members who were caring for young children traumatized by the violent death of a primary caregiver (see the Powell family story, below). More recently, we have begun to work with families for whom exposure to violence—in the home and in the neighborhood—has been chronic and is ongoing. We have found that the protocol is adaptable to a range of circumstances. For example, when a death has occurred, one wants to learn how each family member is grieving and about mourning rituals that are part of the family's religion and culture. If domestic violence is suspected in a child's caregiving environment, the highest priority of an assessment must be consideration of safety of the potential victim(s) and the possible lethality of the batterer (Dutton, 1992).

In its current form, the protocol assesses four areas: 1) the affective qualities of the caregiving environment, including an assessment of the primary caregiver's individual functioning relevant to the developmental needs of the child; 2) the developmental status of the child or children affected by violence or traumatic loss; 3) the quality of the relationships between critical family members and the affected child or children; and 4) the extended family and family structure,

Marva L. Lewis, Ph.D.
Department of Psychiatry
Louisiana State University Medical Center
New Orleans, Louisiana 70112

including grief responses to death, mourning rituals of the family, and the family's coping resources. Our typical assessment occurs during a series of interviews with primary caregivers and family members. However, clinicians and researchers can choose to use parts of the protocol, depending on their interests, skills, training in various measures and procedures, and practical considerations.

The initial interview

The initial interview with a traumatized child's caregivers may take place in person or on the telephone. This interview provides an important opportunity to learn information about the traumatic event and ideas for guidelines for therapy. For example, it is important to ask about the identified patient's relationship with all the people involved in a violent event: One of the child's parents may be the murder victim, the other the perpetrator; a child who has been physically injured in a shooting may have also witnessed the injury or death of caregivers or other loved ones. Ask, as well, about the chronicity of the trauma to which the child has been exposed.

The telephone interview provides an important opportunity for intervention as well as evaluation. Asking generally about a child's symptoms or the specific child-related concerns of the parent provides a beginning understanding of the caregiver's awareness of the child's needs and availability to meet them. It is equally important to ask the caregivers how they are feeling and how they are dealing with their own grief and trauma. Such simple questions acknowledge and validate the caregivers' painful experiences. Many callers experience a degree of relief and at the end of the call express their appreciation that someone understands. The healing has begun.

Shauntell Dillon, a social worker at the New Orleans Children's Bureau, a community agency, recommends a "minute-by-minute debriefing" of families who have experienced traumatic loss. When family members recall and retell the story of the traumatic event in excruciating detail, the information helps to shape the assessment of the child and family and treatment planning. For older children, drawing pictures is a way to tell their story.

A number of appointments may be scheduled and missed before the first in-person interview with traumatized caregivers actually takes place. One mother, for example, whose two sons had been murdered and whose own mother had died shortly before the second child's death, called our office and seemed highly motivated to begin counseling. She missed four consecutive appointments, however. Finally, I called and arranged to meet her for the first time at her own office. There she acknowledged that she had been frightened at the prospect of "feeling the pain" of her losses again by talking about them with a counselor and had found excuses for avoiding our first session.

Assessment of primary caregivers

The assessment of the primary caregivers of a traumatized child should examine the emotional state of each parent or other important caregiver and the extent to which caregivers may transfer or superimpose their own feelings onto the child. The measures used in the initial assessment may be repeated during the course of treatment and at termination to evaluate change and response to therapy.

The first area to explore is the full extent of the child's exposure to violence. Many parents and caregivers are unaware of or deny the multiple ways that children can be exposed to and therefore traumatized by violence. Children may be victims (for example, in a fight with another child), may witness violence or its aftermath (for example, seeing a corpse in the street), or may hear about violence (for example, learning that a friend or family member has been shot) (Osofsky, Wewers, Hann, & Fick, 1993). Thus although a parent or caregiver may be seeking help because of what seems to be a child's response to one specific event or crisis, the child in fact may have been exposed to violence on many occasions and at varying levels of intensity.

Since a surviving parent or other caregiver may have difficulty perceiving the child's emotional reaction and hence may avoid the topic, Weller (1990) recommends asking children who are old enough about their own symptoms and feelings about their parent's death. A helpful tool to address this issue is the survey of children's exposure to violence developed by Richters and Martinez (1993). This survey offers a systematic way to ask parents about a range of violent experiences that their child may have encountered.

Next, begin to explore with caregivers their own history of loss. We have broadened the defi-

nition of loss to include the death of any family members (spouse, other children, and attachment figures from the extended family such as grandparents, or a favorite aunt or uncle); perinatal loss through miscarriage, Sudden Infant Death or abortion; emotional loss in the form of divorce or separation from a spouse; and other trauma-related psychological or symbolic losses identified by the caregiver (for example, loss of innocence through sexual abuse or rape).

The third area to explore is caregivers' beliefs, knowledge, and attitudes about the effects of violence on children. Do they believe that infants and young children remember traumatic events? Do they have information about symptoms of posttraumatic stress disorder in very young children? Does their definition of their parental role extend beyond instrumental caretaker (i.e., provider of food, shelter and clothing) to the crucial roles of nurturer and protector? Do they believe that part of a parent's role is to help children work through grief, or do they believe that their child will simply "get over it?" If the former, what do they believe is the best way for parents to help very young children cope with grief?

Fourth, one should ask about the family's experience with domestic violence and the exposure of adults and children to community violence. As noted earlier, questions should be asked in a manner that reflects concern for the safety of the child and the spouse-victim. Gauging the lethality of the batterer and vulnerability of the children and women should be the first priority (Dutton, 1992). Whether or not safety is an immediate concern, the ability of caregivers to respond to a traumatized child's needs will be influenced by their past and current experiences as victims of domestic violence. Some mothers need a great deal of help seeing the link between a child's exposure to chronic domestic violence and his or her current symptoms. In general, one should become comfortable asking simple, direct questions with a nonjudgmental approach.

It is important to understand when in a family's development violence begins. For example, in some families of physical battering begins during pregnancy.

Finally, we ask about caregivers' perceptions of the safety of their neighborhood. Parents' perceptions of neighborhood safety influence their childrearing strategies. We are learning that in inner-city neighborhoods, where families are embedded in complicated kin and non-kin relationships, ongoing, random contact between children and the perpetrators of violence against their families may be the rule rather than the exception. Young children may walk home from school or go to the corner store and regularly see people who are known "on the street" to have been the perpetrator or "shooter" of their brother, mother, or father. One mother told us that her son's shooter lived in the building around the corner from her own, within the same low-income housing development. In order to walk her three-year-old daughter to preschool, she would have to pass the shooter's house on a daily basis. For several months after the shooting, she could not bring herself to do this. Her solution was to either have her seven-year old child accompany the younger child to school or use the slightest problem as a pretext for keeping the three-year-old home from school. The potential for ongoing random contact with a perpetrator may maintain a level of affect in response to the initial trauma that will be important to understand in assessing the overall caregiving environment and the ability of individual family members to cope with and resolve loss.

Relationship assessment

We assess the quality of infants' and young children's relationships with their parents and other important caregivers by observing their spontaneous interaction during free play (see Zeanah and Scheeringa, this issue). In research conducted with children ages zero to three who have been exposed to trauma and diagnosed with symptoms of posttraumatic stress disorder, two types of distorted parent-child relationships have been identified: 1) role reversal, in which the child becomes the comforter or caretaker of the parent; and 2) the parental child, in which a child is given duties and responsibilities beyond his or her capacity (Scheeringa & Zeanah, 1995). When observing the relationship between a child and any caregiver, one should keep the child's entire caregiving environment in mind. For example, while the relationship between the infant and a primary caregiver may be very distressed (currently or chronically), there may be other, healthier relationships available to the infant within the caregiving environment that serve to compensate for the shortcomings of the relationship with the primary caregiver. If possible, it is useful to have

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these caregivers involved in the assessment, to obtain a clearer picture of the child's needs and to incorporate them into the intervention for the child.

Genogram assessment

The technique of genogram interviews is used to: 1) trace a family's history of death and loss across generations; 2) learn about the family system's grieving process, coping responses, mourning rituals, and affective environment; and 3) place the family within the life cycle of family development. The information gained from genogram interviews is placed within a larger ecological and sociocultural context as we work to understand and support the caregivers of infants and young children exposed to violence.

McGoldrick and Gershon (1989) suggest that the relational structure readily discernable in completed genograms that map at least four generations of families increase understanding of transgenerational themes and allow one to generate numerous hypotheses about the family. Five categories of information may be used for analyses: 1) family structure, which includes household composition and sibling constellation; 2) life-cycle fit, i.e., the extent to which ages of family members and dates of major family developmental events, such as childbearing and death, occur within normative expectations; 3) pattern repetition in individual functioning (e.g., employment or alcoholism) and relationship conflicts across generations; 4) the temporal connection between life events, such as the death of a family member, and the occurrence of other family developmental milestones such as births and marriages; and 5) overall patterns of family functioning (e.g., the proportion of children in the family who become emancipated and marry).

Multigenerational reports of the family's structural history

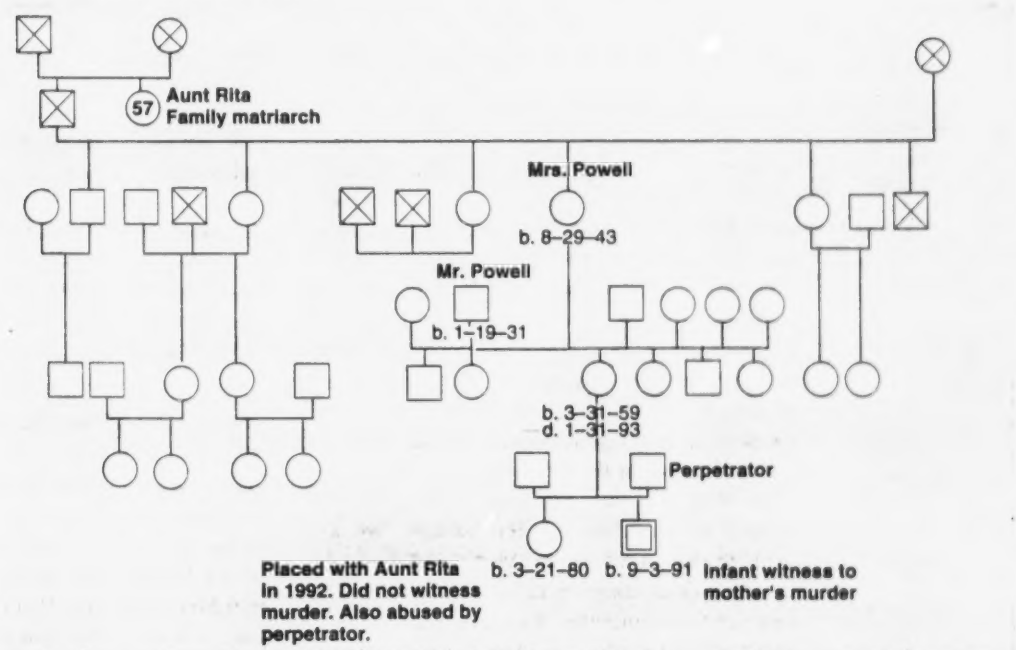
In order to assess generational patterns and themes of loss, change, and family myths, we ask family members from different generations to provide information individually on aspects of the family structure and roles. First, we create a map of four generations, beginning with the infant (see Figure 1, a genogram of the Powell family, to be discussed below). We ask family members about:

- Naming patterns; birth dates of family members; cohabitation patterns (dates of marriages, periods of living together, separations, and divorces).
- Education, job stability and retirement, military service, and membership in organizations.
- The family's history of deaths, including dates, causes of death, and perinatal losses. We have found it important to learn about miscarriages, abortions, stillbirths, and neonatal deaths, including, in the latter cases, whether the family named the dead infant, had funeral services, etc. These circumstances may influence the relationship between caregivers and the next child born into the family after the loss.
- The family's history of separations. We ask about residential and mobility patterns in the family, dates at which family members left home, current whereabouts, dates and duration of extended hospitalizations, and prison terms. We also ask about informal adoptions and "shared parenting" practices that are common in some cultures, especially African-American culture. Since the entire assessment is conceptualized in terms of loss, we explore the losses that may be involved in a move (i.e., loss of friends, transfer from a familiar school), as well as in separations from caregivers or loved ones.

To complement the four-generation map, we ask about family roles that existed within the extended family network before the violent death occurred which brought the family to us for consultation. To learn quickly about the personality characteristics of members of the extended family, we ask each reporter to tell us the nicknames of people in the genogram, and their origin. Nicknames reveal a great deal about how an individual is perceived within his family—is he the family hero or the family scapegoat? Does the origin of a nickname suggest alcohol or drug abuse? We also ask about the relationship of each individual in the genogram to the target infant or young child: Does the individual serve as caretaker, playmate, or protector of the child? Finally, we pay close attention to the sibling subsystem in a family where trauma is reverberating. We are sensitive to the possibility of survivor guilt, and we also want to be alert to the development of symptoms among the siblings of the infant or young child who is the identified patient.

In order to understand stresses on the family, we ask about social and economic circumstances and intergenerational patterns of family structure

Powell Family Genogram/Mrs. Powell



—i.e., single-parent, nuclear, or extended family structural patterns. We assess the family's position within the family developmental life cycle and consider the tasks associated with the phase, to weigh the impact of the current loss. For example, as the case vignette below illustrates, grandparents who assume the role of primary caregivers for a bereaved infant are likely to find the responsibilities very different from the developmental task of adjusting gracefully to retirement, which they had been anticipating at this time in their lives.

The family's grieving process

Our genogram-based interviews teach us a great deal about individual and intergenerational responses to death in a family system. Rev. Torin Sanders, a social worker with the New Orleans Children's Bureau, recommends asking all family members their response to hearing the news of the death in question. Like the minute-by-minute debriefing of victims of or witnesses to violence, this process allows people to reconstruct the event and tell their own story about the trauma. Family members' answers to the question, "How did you respond to hearing the news?" reveal important individual differences and may also lead to recollections about "hearing the news" of other deaths in the family. Asking about the duration of the grief response of selected members of the family is a way of learning family patterns or rules about the length of time it is permissible for people to grieve. Families may have beliefs, attitudes and expectations concerning appropriate grief responses that are different for males and females, or for adults and children. When an infant or young child is being assessed, it is important to understand the meaning of family members' responses to the child in the context of the family's grieving process. Is the infant (particularly one who has lost a parent) now the center of the entire family's attention? Is the child an object of pity or a distraction from the family's grief work?

Family caretaker

Another important area to assess in the family structure is who has assumed the role of instrumental and emotional caretaker—for the family collectively and for the referred infant specifically. When the family system has been immersed in chronic trauma, we suggest that a medical examination of the primary caretaker be completed. Sleep disturbances and eating disorders are common among caregivers who are immersed in chronic trauma and whose infants have been exposed to an acute episode of violence.

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Family mourning rituals

Every culture has distinct beliefs and rituals associated with dying, death, mourning, and grief. The family's cultural identification will influence funeral practices and ceremonies. For example, is an open or closed casket the norm? Is there a prescribed period of mourning before family members are expected to return to daily responsibilities? Are young children expected to attend or participate in the funeral ceremony? Violent or unanticipated death may interfere with expected rituals—for example, the opportunity to "say goodbye" in an open-casket funeral. A family so bereaved may need to create its own ceremonies of farewell, as well as healing ways to remember the dead at family gatherings and reunions and on the anniversary of the death.

As we talk with families and colleagues from various locations around the country, we are learning that visions of or "visitations" from the dead are quite common in low-income, African-American communities. Family members of all ages and both genders are likely to say, "Grandma came by to see me"; "My boyfriend came and talked to me"; or "My (dead) child was in the room with me—I heard him crying." We need to learn more about how long it is "ok" within a particular culture or family for the dead to appear to the living and at what point the visitations are considered symptoms of emotional disturbance.

The family's coping resources

We draw on an ecological approach to child and family development in order to assess the social support and coping resources available to a grieving family, creating an "eco-map" of support. First, we look at formal community resources, including grief support groups and programs for victims and witnesses of violence. Particularly in the context of grief and loss, a family's religious affiliation or spirituality constitutes an important dimension of the family's coping resources. What are the doctrines of the family's religion concerning death, grief, and loss? The family's religious beliefs may affect caregivers' attitudes and expectations of therapeutic intervention.

Characteristics of relationships within a particular family have a major impact on the family's ability to cope with stress and loss. Characteristics such as flexibility and adaptability, emotional expressiveness, and communication styles are especially important to consider.

The Powell family[1]

Our work with the Powell family shows how the family assessment becomes the foundation for clinical intervention.

Sadie Powell called our clinic, concerned about her two-year old grandson, David, who had witnessed the murder of his mother, her daughter Tonya, by David's father, 11 months ago. David's 13-year-old sister, Debra, who had been staying with relatives, did not witness the murder. Mrs. Powell and her husband were planning to adopt David. Mrs. Powell had been employed full-time but decided to quit her job in order to care for David.

Assessment of primary caregivers

In initial interviews with Mr. and Mrs. Powell, they spoke of their concern about David's aggressive play and nightmares. David initiated many fights with other children and gunplay always seemed to be a part of his pretend play. Both Mr. and Mrs. Powell felt that it was their role to provide care and protection for David. Their daughter's murder and David's symptoms evoked in Mr. Powell vivid memories of his wartime experiences, in which he had lost a number of buddies to violent death. Mrs. Powell had her own history of unresolved loss and family secrets. For example, when the genogram was completed by other family members, it was revealed that Mrs. Powell's daughter was believed to be the result of a rape of Mrs. Powell by another family member when she was a teenager. This particular dynamic became important to understanding the complexity of the conflicted relationship that existed between Mrs. Powell and her daughter prior to her death. On a standardized measure of grief resolution, Mrs. Powell showed very little resolution and acceptance of her daughter's death almost 11 months after it had occurred. Along with photographs of her daughter, she carried her daughter's obituary, almost as a way of reminding herself of the reality of the death.

Genogram interviews

The four-generation map of the extended family helped us to explore a number of important relationships and themes in this family. For example, it was Mrs. Powell's Aunt Rita, the family matriarch, with whom Debra was living at the time of

1 The names and identifying details have been changed to maintain confidentiality.

Tonya's murder. Exploration of pre-mortem family roles revealed that Mrs. Powell had disapproved of Tonya's relationship with her boyfriend, who later moved the household out of state. The move effectively prevented the formation of any relationship between Mrs. Powell and her grandchild David, and Mrs. Powell had not seen her daughter for almost two years before her death.

The family developmental life cycle assessment revealed that both Mr. and Mrs. Powell felt they had completed their developmental task of parenting and were preparing for retirement. In order to address the needs of David and Debra, they had to make a drastic developmental reversal, becoming once again a child-centered family. Mrs. Powell chose to quit her employment in order to provide full-time care for David, with full support and blessing from her husband.

Coping resources were plentiful in the Powell family. David was attractive and highly intelligent. Mrs. Powell was very religious and viewed her relationship to God as a powerful source of strength. She prayed regularly, attended Mass, lit votive candles, and "kept the children in her prayers." The extended family network was strong. David was able to stay with a great-aunt (Mrs. Powell's sister) immediately after his mother's death. Even though Mrs. Powell thought that her sister was insufficiently sympathetic to David's immediate psychological needs, she nevertheless was available. Other members of the extended family living near the Powells interacted frequently with them and David. More senior family members were enlisted to pray for David's well-being.

The violent circumstances of Tonya's death created conflict in the family around appropriate mourning rituals. Because the gunshot wound to her head had been disfiguring, Mrs. Powell ordered the casket closed, over the objections of other family members. Debra, in particular, who had been living with Aunt Rita for almost a year before her mother's murder, blamed her grandmother for not letting her see her mother's body and "say goodbye."

Clinical intervention

Although our assessment of Mrs. Powell suggested that she might benefit from individual therapy to help her resolve her own feelings about her daughter's death, the Powells had come to us because of concern for David's well-being. Mrs. Powell's difficulties in accepting her daughter's death did not seem to be interfering with her ability to care for David. Consequently, our approach was to educate the Powells about traumatic stress symptoms in children and the grief process, and to enlist them as co-therapists. As it happened, assumption of this role helped Mrs. Powell organize herself psychologically and led to increased self-esteem and respect from others in the extended family for her competence as a caregiver.

David began individual play therapy. As we and the Powells observed David's play during the assessment and ongoing therapy, we discussed the themes revealed in the play and possible interpretations. Mrs. Powell reported her observations of David's behavior between sessions, and we discussed the extent to which these behaviors had been predicted or unexpected. We talked about possible therapeutic responses to David's expressions of grief and posttraumatic symptoms. It was Mrs. Powell who creatively found ways to integrate Catholic rituals into a therapeutic process for David; for example, when he experienced nightmares, she would sprinkle him with holy water. Early on, the couple allowed David to sleep with them when he had nightmares; they were able to proudly note his achievement of sleeping alone in his own bedroom as a concrete sign of healthy progress based on therapy.

Participation in play therapy for David gave Mrs. Powell a unique role in the extended family system as an "expert" on grieving and traumatic stress symptoms in children. She was able to share her knowledge and educate the extended family on David's unique needs. Rather than simply responding with vague responses, such as "he's doing fine" to family members' inquiries, she could respond with concrete descriptions of behavioral change she had been coached to notice during therapeutic play.

Education and preparation for the developmental process of grief work were important in our relationship with the Powells. We discussed the fact that as David's cognitive capacities and verbal skills increased, he would continue to rework his understanding of death, dying and loss (Terr, 1990), and would need additional support and understanding as the loss of his mother took on new meanings.

Caregivers of traumatized young children need support around decisions concerning their

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relationships with community agencies, such as school and health care systems. It is important to include teachers as partners in supporting traumatized children as they work through their grief process (see Garbarino et al (1992) for methods and issues to be addressed with educators). However one wants to avoid creating a situation in which children are stigmatized as "special," particularly when there is actual or potential sensationalism. Terr (1990) suggests that caregivers be counseled to return for follow-up appointments at critical points in children's development, so that they can learn to assist them in re-working the trauma.

Conclusion

During the past three years, we have worked hard to understand and support the parents, grandparents, family members, foster parents, child care providers, police officers, teachers and neighbors who constitute the caregiving environment for infants and young children exposed to violence and traumatic loss. We have seen how the experience of trauma reverberates throughout a caregiving environment. We have also seen how knowledge and understanding of the experiences of children and their caregivers can begin a healing process that also reverberates. We hope that the protocol described here will assist other clinicians in understanding the strengths and vulnerabilities of people faced with the tremendous challenge of caring for young victims of violence. We feel this protocol offers an opportunity for intervention during the assessment process. We also recognize that we must broaden still further our conception of what constitutes the caregiving environment of traumatized young children. We must learn more about how these children are treated in the educational and mental health systems. We also need to continually reconsider the social policies that govern their treatment—and that may place them at risk.

It is in their own homes that many children become witnesses to violence for the first time.

Children without Refuge: Young Witnesses to Domestic Violence

Betsy McAlister Groves, LICSW

It is in their own homes—not their neighborhoods—that many children become witnesses to violence for the first time. And domestic violence is an "equal opportunity phenomenon"—intentional violence between adults occurs in households of every class, race, and level of education, and in every part of the country. Children who live with chronic domestic violence are deeply affected by their experiences. Indeed, they often suffer more enduring harm than children who are exposed to community violence. This essay will review what we know about young children's exposure to domestic violence, describe the multi-systems evaluation and treatment approaches of the Child Witness to Violence Project (CWVP) at Boston City Hospital, and illustrate, through a case example, direct therapeutic work to help a young child cope with the aftermath of inter-parental violence.

Children's exposure to domestic violence

It is estimated that each year at least 3.3 million children witness physical and verbal abuse among adults in their homes—behaviors ranging from insults and hitting to fatal assaults with guns and knives (Jaffee, Wolfe, & Wilson, 1990). Data collected from restraining order forms filled out by women seeking protection from the courts (Massachusetts Department of Probation, 1995) suggested that in 1994, 43,000 Massachusetts children were exposed to domestic violence; 65 percent of these children were 8 or younger. In many communities, over half the calls for police assistance involve domestic disturbances. Although violence may be instigated by women and occurs in same-sex couples, the large majority of documented domestic violence incidents involve a woman as victim and a man as perpetrator. In a recent Social Policy Report for the Society for Research in Child Development, Osofsky (1995) cites nationwide surveys showing that nearly one-eighth of husbands in the United States commit one or more acts of physical violence against their wives each year; 20 to 33 percent of all women are assaulted by a partner or ex-partner during their lifetime.

A 1991 survey of parents in the waiting room of Boston City Hospital's Pediatric Primary Care Clinic, designed to find out about the violence young children were witnessing, yielded disturbing—and surprising—findings (Taylor et al., 1994). We interviewed 115 mothers, all of whom had at least one child under the age of six. The mean age of children in the sample was 2.7 years. We asked mothers how much violence their young children were witnessing, where the violent incidents occurred, and whether mothers had been victims of violence. We found that by the age of 6, one in 10 children had witnessed a knifing or shooting. An additional 18 percent of children under six had witnessed pushing, hitting, or shoving. Half of the reported violence occurred on the street; half occurred in the chil-

Betsy McAlister Groves, LICSW
Child Witness to Violence Project
Boston City Hospital
Boston, Massachusetts 02118

dren's own homes. Nine percent of mothers had been a victim of violence.

We were startled to discover the percentage of young children in our community who had actually witnessed severe violence. We were equally surprised that so many mothers reported violence in the home. Later, as we began to work therapeutically with families, we learned that many parents in violent homes believe that their children are unaware of violent incidents because the child "was sleeping" or "in the next room with the television on." When we interview children, however, we discover that they have generally seen and heard much more violence than their parents realize.

In order to ward off some of the long-term consequences of children's traumatic exposure to violence, we began the Child Witness to Violence Project at Boston City Hospital. The project provides early intervention to children eight years old and younger who have witnessed significant violence, and to their families. Since the project's beginning in 1992, we have seen approximately 150 families. About 40 percent of referrals are for children age 4 and younger. Although we expected that most referrals would involve children who had witnessed community violence, two-thirds of all referrals have been for children who have witnessed violence in their own homes.

How witnessing domestic violence affects young children

We have learned a great deal about the insidious nature of domestic violence and about how witnessing violence affects young children's functioning and development.

• **Children who are present during an incident of domestic violence are at increased risk for becoming direct victims of child abuse.** In homes where domestic violence occurs, children are physically abused and neglected at a rate 15 times higher than the national average (Hearings before the U.S. Senate Judiciary Committee, 1990). In some cases, children are unintentional victims of an interparental attack: Older children may be injured while actively trying to protect the mother; younger children and infants may be injured because they are unable to get out of the way of an assault directed at the mother. Several studies have found that in 60 to 75 percent of families where a woman is battered, children are also battered (Bowker, 1988; McKibben, DeVos, & Newberger, 1989; Straus, Gelles, & Steinmetz, 1980).

• **Witnessing domestic violence produces symptoms associated with Traumatic Stress Disorder.** As Zeanah and Scheeringa (this publication) observe, child witnesses to violence are at higher risk for traumatic stress disorder if they are at close proximity to the violence, if they have a close relationship to the victim or the perpetrator, and if they perceive themselves to be vulnerable to injury. Children who witness domestic violence fulfill all of these criteria.

• **Children who live with domestic violence learn, early and powerfully, that violence is a part of intimate relationships.** They learn that violence is an appropriate way to discharge tension and resolve conflicts. They learn that the perpetrator of violence in family relationships often goes unpunished. They learn that violence is an acceptable way to control other people. They learn that violence is connected to the expression of love.

• **When violence occurs in the home, children have no refuge.** When violence occurs in the community, families may experience an initial period of disequilibrium and dysfunction, but many parents are able to rally—often in creative and heroic ways—to protect their children, both physically and psychologically. This is not the case in situations of domestic violence. Here, one parent is the perpetrator and the other is the terrified victim. To whom does the child turn? The child has no one.

Mothers' dilemmas

Mothers in our project have painted a vivid picture of their lives and the lives of their young children in violent households. Anxiety and fear are chronic; neither mother nor children are able to anticipate when the next violent event will occur. Households become organized around the abuser. Mothers describe being constantly watchful in an effort to anticipate and ward off their partner's next violent outburst. An infant's crying or a toddler's rowdy behavior may be seen as the precipitant of a violent outburst. Thus young children, who lack cognitive maturity yet are trying to make sense of events around them, may incorporate the belief that they are somehow responsible for adults' violence.

When a mother decides to leave her partner,

the children's situation may actually worsen. Mothers (and children) are at continued or increased risk of being harmed after they make the decision to leave the relationship. The batterer often reacts with anger, disbelief, and increased attempts to control the woman's relationship. Many women we have seen in the Child Witness to Violence Project described escalating danger as their partners attempted, sometimes through desperate means, to find them and persuade them to return home.

When women and children actually leave home, they are usually fleeing in terror. Suddenly, children are uprooted from all that is familiar — their home, their schools, and their community. Seeking refuge in a shelter for battered women means living with a number of other families who are enduring similar stresses. Children's routines are disrupted: they must adhere to the shelter's regimen. Although shelter rules may be necessary to protect women's safety and to cope with the logistics of housing multiple families, rules may not be child-friendly or even child-appropriate. Consequently, children's behavior often deteriorates. They don't sleep; they are clingy; they are aggressive. Mothers begin to wonder if they have done the right thing—maybe they shouldn't have left their partner after all.

The story of Mrs. A. and her three children, who had left a violent home several weeks before I met them, powerfully illustrates the dilemmas mothers face. Mrs. A. had sought help from our project because of the aggressive behavior of the three-year-old. As we met together, the children, ages 3, 9, and 11, began to talk about what it had been like to leave home. The older two children knew that they were now safe and could express some relief. But they also talked about what they had left behind—their favorite toys, their friends at school, and, most painfully, their dog. The children began to cry when they talked about the dog. As I looked at Mrs. A., the sadness in her face helped me to understand the guilt and doubts she had about whether she had done the right thing in making a choice that would seem so obviously correct to most of us—leaving a husband who had seriously injured her more than once and who represented a threat to the very lives of herself and the children. Mothers who are considering leaving a violent relationship need a great deal of support to help them: 1) anticipate the difficulties their children are likely to experience during this period; and 2) maintain their resolve to end the violent relationship.

When mothers who are victims of domestic violence develop symptoms of Post-Traumatic Stress Disorder, their parenting is affected. Mothers may become desensitized to the impact of violence on their children, and their judgment about protecting their children from exposure to violent or traumatic material may be impaired. Mrs. B., the mother of three children ages 3-7, decided to leave her husband after he attempted to smother her in the presence of the two youngest children. In our first evaluation session with the family, Mrs. B. began to recount the details of this horrifying event. As she talked, all the children become more and more agitated. finally, the 7-year-old began talking so loudly that his voice drowned out his mother's. Mrs. B. seemed oblivious to the effect that her story had on the children. Her trauma had been so massive that she could no longer make judgments about what or what not to say in front of her children. The clinician acknowledged and validated the mother's strong need to talk about her experiences but cautioned her against discussing the more gruesome aspects of the events in front of her children.

Mothers who are victims of domestic violence may misinterpret normal aggression in their young children, especially boys. Some aggressive behavior is, of course, part of young children's normal repertoire. But for mothers who have been victimized, typical aggressive behavior may become highly charged, reminding them of the perpetrator's behavior. This, in fact, is one of the more common worries that prompt mothers to call our program: "He's behaving just like his father" or "I'm worried that he will turn out to be like his dad," a mother will say, describing a two-year-old hitting or kicking a sibling. Mothers are unsure about how to interpret the aggression they see in their young children: Is it a normal part of the child's development, or is it intensified because of the violence the child may have witnessed? These are difficult questions—ones that continue to be debated among practitioners who work with children.

A multi-systems approach to helping children affected by domestic violence

Mental health clinicians, teachers, or health care providers alone cannot provide help to families

affected by domestic violence. The complexity of families' situations requires a multi-systems approach, including law enforcement and the courts. Sometimes the rapid decision-making of crisis intervention is involved; at other times, the child's interests or needs may be in conflict with the mother's interests. Professionals involved in this work are forced to look carefully our own biases, to discover how our gender, culture, ethnicity, and life experience may be affecting our assessment of families and influencing our judgments.

An ideal intervention for families affected by domestic violence would first respond to the crisis of violence by reestablishing safety and stability and, second, work therapeutically with both mother and children. The first priority, when domestic violence has occurred, is to stop the abuse. Intervention usually involves working with the law enforcement system to remove the batterer from the family. The clinicians in our project have learned a great deal about how to collaborate with police officers to help women, how to obtain restraining orders, and how to negotiate visitation. Becoming skilled advocates for women and children involves learning critical details—the specifics of each state's domestic violence statutes, and which judges and attorneys can be relied upon for help.

Therapeutic work with mothers who are victims of domestic violence is aimed at: 1) treating posttraumatic stress symptoms; 2) supporting or strengthening the mother's ability to parent her children; and 3) helping the mother to create more stability and structure in the family. Treatment may be provided individually and in group settings. Therapeutic work with children is designed to help them process the trauma they have experienced and to come to a more complete understanding of the events that have occurred. Children need to grieve over the loss of the parent no longer living with them (usually the father) and to integrate the entire experience into their emerging sense of self.

The reality of our work with families affected by domestic violence often falls far short of this ideal. When mothers cannot leave their violent partners—because they have no money, because they have nowhere to go, or because they are psychologically unready—we may find ourselves trying to work therapeutically with a family while the threat of abuse continues. In these circumstances, our task is to help the mother assess the potential for danger, and to assist in developing some strategy that will protect her and her children if violence escalates. We may need to involve protective services for the children. We may refer the mother to a support group or put her in touch with a shelter. Perhaps, most importantly, professionals must remain available to mothers, consistently communicating their support and their belief in mothers' abilities to know what is best for themselves and their children.

Caught in the crossfire: Julie's story

In my 15 months of therapeutic work with Julie and her family, we were able to move beyond basic issues of safety and housing to focus on the complex psychological needs of the child. Julie's story also illustrates the enormous difficulties children face when their parents are at war with each other.

Julie, age 3 years, 4 months, and her mother, Mrs. Jones, were referred to the Child Witness to Violence Project by a victim advocate from the municipal court where Mrs. Jones had obtained a restraining order against her husband. Mr. Jones had, however, recently violated the order by contacting his wife; he had been arrested. Upon his release from jail, he agreed to seek his own apartment and to refrain from contacting his wife and family.

This event marked the end of an 8-year relationship that, according to Mrs. Jones, was characterized by Mr. Jones' extremely controlling behavior, emotional abuse, sexually coercive behavior, and occasional physical assaults. When Julie was 2 1/2 years old, she witnessed two physical assaults by her father on her mother, one occurring on Christmas Day. Mrs. Jones was concerned about Julie's nightmares, refusal to sleep alone, and increasingly aggressive behavior.

Julie is a bright, engaging child with excellent verbal skills. For the first eight months of treatment, she demonstrated her general level of anxiety and her strong need for structure and predictability by establishing rituals and routines for our sessions and adhering to them strictly. We began each session by sorting beads. Then we played with animals and dolls. Then we read a story, usually "Goldilocks and the Three Bears."

In the animal play, Julie would sort the animals into the "bad guys" and the "good guys."

The bad animals were the dinosaurs, tigers, and sharks—generally any animal with teeth showing or with a fighting, aggressive posture. Because they were bad, these animals were banished. Julie spent a great deal of time banishing animals, putting them under a chair in the far corner of the room. As she did this, she explained that the animals were bad because they hit and kicked. Julie put the good animals in a doll house, which she made safe by piling blankets on top. The good animals stayed in the house, and the bad animals couldn't get to the good animals.

I came to see Julie's play as her effort to review and understand what had happened to her father. Her father, who hit and kicked, had been banished from the house; he was bad. I had further clues about the meaning of this ritual as Julie told me about missing her father; one day she also told me about how she had kicked a child in her school. Julie was showing me that she had very concrete and disconnected notions of goodness and badness — as was developmentally appropriate for her age. Kicking is bad; her father kicked; her father is bad; he had to leave. But Julie had also kicked — would she also be banished?

I also knew that Mrs. Jones, who was enraged at her husband, had difficulty hearing from Julie that Julie missed her father. It was important that Julie was able to tell me that she missed her father and that I could reflect with her how sad she must be that her Daddy didn't live with her. I also directly addressed her worries about being banished from her house by making a distinction between children's behavior, because "they are just learning the rules and need lots of practice," and adults who know the rules "because they are grown-ups." She seemed reassured by this distinction.

After more than eight months of animal play, we were able to move to a more direct examinations of Julie's concerns. She began to ask me to "write sentences" for her:

My daddy hit my mommy and the Christmas tree fell down.

I don't like it when my daddy is mean to my mommy.

Don't be mean, Daddy.

If my daddy hits my mommy again, I will throw my sweater at him and make him stop.

I'm thinking my mommy might get lost.

Julie's "sentences" revealed the power of violence in her life. The incident on Christmas day had occurred two years earlier — half a lifetime ago, for Julie — yet she was still talking about it and able to recall specific details of the violent event. The sentences also reveal Julie's concerns about her mother's vulnerability. Mrs. Jones is extremely fragile and unable to contain her anxiety and intense feelings about her husband. She is seen in individual therapy to focus on the issues of abuse and trauma in her life. Despite a visitation schedule with a pick-up and drop-off arrangement that prevents direct contact between Julie's mother and father, Mrs. Jones' anxiety around visits is obvious, and she questions Julie about details of the visit with her father. Even though she is safe physically, Julie is caught in the emotional cross-fire of her parents' struggle, feeling protective and loyal to her mother and also feeling some responsibility for her father.

Currently, Julie is doing well in pre-school. She is seen as a capable child who is curious, sociable, and outgoing. She will enter kindergarten in the fall, necessitating a change in schools. This transition may be difficult, stirring up anxiety about separation.

In therapy, I will continue to help relieve Julie of the responsibility she feels for her parents' behavior by providing a neutral, safe haven where she can talk, play, draw, and share her worries. I will continue to work directly with her parents to discuss ways to minimize the impact on Julie of divorce and custody proceedings. One of my greatest challenges will be advocating for Julie's best interests before the judge who will make decisions about visitation and custody. Julie's needs are in danger of being overlooked completely as the court considers whether Julie should have overnight visits with her father, whether the visits should be supervised, or whether the visits should be stopped altogether. Not surprisingly, Mr. and Mrs. Jones have very different ideas of what arrangement would be best for Julie, and each wants my recommendations to support his or her wishes. Fortunately, the court has appointed a guardian ad litem for Julie to provide an assessment and make recommendations to the court. The assistance of the guardian ad litem allows me, as the therapist, to continue to advocate for the child and to be the child's refuge from the struggle between her parents; I will not have to take sides between battling parents, therapists, and lawyers.

Julie's story — in which courts, therapists, and

schools all played important roles—illustrates the conflicting interests and complicated systems that are involved in working with children who are affected by domestic violence. The complexities of the systems mirror the complexities of the problems experienced by families in which domestic violence occurs. Strategies for intervention must take into account the multiple systems that affect children's lives, and treatment must include a contribution from **each** of these systems. Only then can we hope to work effectively with families who are affected by domestic violence.

After James Darby was killed, I and many of my staff were so distressed that we questioned whether we could face continuing to work with children and families traumatized by violence.

When the Helper Is Hurting: Burnout and Countertransference Issues in Treatment of Children Exposed to Violence

Joy D. Osofsky, Ph.D.

Dear Mr. Clinton,
I want you to stop the killing in the city. People is dead and I think that somebody might kill me. Would you please stop the people from deading. I'm asking you nicely to stop it. I know you can do it. Do it now. I know you can.
Your friend,
James

Nine days after writing this letter, nine-year-old James Darby, who participated in the New Orleans Violence Intervention Project for Children and Families (VIP), was killed unintentionally in a drive-by revenge shooting. It was Mother's Day, and James was walking home from a picnic with his family.

James Michael Rovaris is a staff member of our VIP team. Mr. Rovaris had interviewed James Darby just before he wrote his letter to the President and also made a drawing of what happens in his neighborhood. When James was killed, Rovaris, like his colleagues, was devastated. He recalled that he and James had talked about the fact that they both shared the same name.

When parents lose a child, we recognize that they can suffer no greater tragedy. When children die violently, we recognize that the entire community will be affected. But we pay relatively little attention to the specific impact of violence on adults who work daily with young victims of violence, yet are not parents and may not be neighborhood residents. Teachers, child care providers, health care and social services workers, and the police know children who are victims or witnesses to violence. These professionals may have to deal with the immediate physical aftermath of violence or may find themselves coping with its ongoing psychological effects—for example, the disruptive classroom behavior typical of traumatized children. Whatever their connection to young children and violence, community helpers are also likely to be hurting and in need of relief and support.

James Darby had touched all of us in the Violence Intervention Project. After he was killed, I and many of my staff were so distressed that we questioned whether we could face continuing to work with children and families traumatized by violence. We found it extremely difficult to understand or accept James' death. Recognizing that avoidance and denial are expectable defenses against trauma, I created a special supportive group setting and invited a social worker from outside the project to facilitate the group, so that staff could talk about their feelings and, eventually, move on. By confronting our feelings of helplessness directly, we were able to resume our work of assisting people much more directly touched by violence—children, parents, neighbors, and front-line community workers.

Burnout and countertransference

The feelings that I and my staff experienced after James' death have been described in different

Joy D. Osofsky, Ph.D.
Department of Psychiatry
Louisiana State University School of Medicine
New Orleans, Louisiana 70112

ways. The term "burnout" has become familiar throughout the helping professions as a way to describe practitioners' reduced effectiveness, often accompanied by feelings of helplessness, hopelessness, frustration, anger, or cynicism. The technical term "countertransference," from the field of psychotherapy, is defined as "the therapist's emotional reactions to the patient that are based on his or her *unconscious* needs and conflicts as distinguished from his or her *conscious* response to the patient's behavior. Countertransference may interfere with the therapist's ability to understand the patient and may adversely affect the therapeutic technique" (*American Psychiatric Association Glossary*, 1994, p.32, emphasis in original). Mental health professionals are usually trained to become aware of and understand the feelings from past relationships that patients may bring with them to the experience of therapy ("transference"). Sometimes, however, less attention is given in our training to the very important issue of the countertransference. If not understood, the countertransference of the therapist can interfere with treatment.

As described above, the killing of James Darby seemed (and was) so senseless and random that many of staff members of the Violence Intervention Project began to feel helpless. We began thinking that what we could do was so little and probably didn't do much good anyway. Had we carried these feelings, unexamined, into our relationships with James' family and neighbors and with other children and families traumatized by violence, we would, indeed, have been impaired in our ability to help. We may even have done harm. An experience from the fall of 1994, less than six months after James Darby was killed, illustrates the importance of paying attention to countertransference.

In September, 1994, twin boys, almost three years old, were brought to our children's clinic by their maternal grandparents, who had been given custody of the boys after their father shot and killed their mother in front of the youngsters. The toddlers reportedly fought constantly, woke up repeatedly with nightmares, were afraid to sleep alone, had accidents after previously being toilet-trained, and could barely communicate with language, although they had been understandable to adults before the trauma. Their affect was dull and they rarely smiled; their play quickly degenerated into fighting.

The boys were seen in individual play therapy by a female child psychiatrist, and the grandparents were provided with grief counseling and parental guidance. A senior child psychiatrist and I, a senior clinical psychologist, provided supervision. With the grandparents' permission, all treatment sessions were videotaped. Tapes were reviewed as part of clinical supervision with the front-line therapists, and some were used for training other staff in this form of treatment.

Over the course of the 10 months of treatment, the twins started to play and express the positive feelings typical of children their age. As they developed stronger coping strategies, they also played and acted out the trauma they had witnessed. From behind a one-way mirror, I would often observe the twins playing with their therapist, and once a week I would review with her the videotape of their session.

At times, as I observed the twins with the therapist, I was aware of feeling angry and frustrated. Some days, I found myself feeling extremely angry at the father who had done such a terrible thing to these very little boys, not only by killing their mother but, in addition, by forcing them to witness so much violence at such a young age. I was saddened thinking of how these young children were needlessly made to suffer. It was important for me to recognize consciously what might be setting off my emotions in order to help guide their treatment in a sensitive, facilitative way. This was particularly important because their treatment had to involve the boys coming to grips with all of their feelings about their father. He was not only the violent man who had killed their mother but also the involved father who had nurtured his twin sons, taken them to the pediatrician, and spent a lot of time with them when their mother worked.

Being aware of my, at best, ambivalent feelings toward the father was extremely important for the supervision in a number of ways. First, it was important because the therapist might be experiencing similar feelings, as yet unrecognized consciously. Second, it was important for us to consider and discuss how to help the twins deal with their ambivalent feelings toward their father—that is, to be able to integrate the good with the bad. This issue was one of continuing importance for the therapeutic work.

This situation reminded me of how important it is for therapists—and their colleagues and supervisors—to be aware of the powerful feelings likely to be evoked in work with traumatized

young children. If the treater is also traumatized by the experience or does not have the opportunity for reflective supervision and support, empathic understanding of the patient and situation may be more difficult. Some practitioners may lose their sense of boundaries; frequently workers have the strong impulse to "take the kids home and care for them." Alternatively, workers may become "burned-out" and withdraw from appropriate engagement. Interestingly, some treaters believe it may actually be useful at times to feel overwhelmed and helpless when faced with a young child who has been traumatized. In this way, the treater may be able to be even more empathic with what the family and/or caregivers may be experiencing (Personal communication, Dr. Lisa Murphy, Trauma Psychiatry Program, UCLA, April 25, 1996). Whatever the feelings he or she experiences, if the treater stays in touch with them, they can inform and enrich the treatment. Unacknowledged, unrecognized, or unexamined countertransference responses can damage the work of both the client and therapist.

Working with mothers who have lost children to violence

The impact of countertransference on our daily work quickly became apparent after a group of mothers asked our team from the Department of Psychiatry at Louisiana State University Medical Center for counseling around grief and loss. These mothers were founders and leaders of the Moms Against Violence Program, a grassroots violence prevention and intervention initiative designed to provide education, support, services and counseling to children and families who are exposed to violence in the neighborhoods in which they live. All of the mothers live in public housing and each has lost a child to violence.

Moms Against Violence leaders asked us to help them build their strength to do the work of supporting neighborhood residents who reach out to children and families to help them cope with the stress of violence and to act as role models for younger children. In addition, we provide training on how violence affects children and specific skills for helping children and families, including active listening and conflict resolution strategies. When I originally began work with the mothers, with my colleague, Marva Lewis, we felt it that it would be extremely important for mothers to share within the group their experiences of loss and grief, especially the loss of their child.

In the first group meeting, we encouraged participants not only to share their stories, but also to let themselves experience the emotions that accompanied the telling. I went home feeling depressed and strangely irritable. It was not until I was able to get in touch with my own belief that one of the worst experiences a parent can have is to lose a child that I understood and was able to deal with my emotions following that meeting. Most people have experienced some significant losses in their lives, and hearing about and empathically sharing others' losses may reawaken some of those feelings. Again, a therapist or counselor who is not in touch with his or her countertransference may be limited in his or her empathic understanding and, ultimately, the ability to help.

We learned from this experience, as well as the many educational presentations we have done, that powerful feelings may arise as one talks about children and violence, and especially about children who have been killed. We have learned that it is important to bring this issue up at the beginning of the experience. When we do training in the future, we will do more anticipatory guidance and framing to prepare participants for the possible post-meeting impact of sharing these painful stories. We are aware of the need to provide back-up support for the mothers as they go out into their communities to work with other mothers and families, since their own painful feelings may be reawakened by such experiences. We are building relationships with these mothers so that they know they can trust us, and count on our availability as well as our expertise.

Working with police officers

Our society expects mothers who have lost their children to grieve. But we seldom acknowledge that seasoned police officers may be traumatized by their involvement with children exposed to violence. A senior police officer with whom we work on community violence prevention activities told me of feeling overwhelmed when he saw "guts coming out of the stomach" of a seven-year-old who had been shot accidentally; the officer had to leave the scene briefly to contain his emotions before he could respond efficiently. More frequently, police officers go out of their way to try to offer comfort to children and family members when a child has been a victim or witness to violence. Police officers seldom talk about their emotions publicly. However, after a trusting rela-

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tionship has been established, they often find it supportive and helpful to be able to talk about what they feel in traumatic situations involving children.

As part of the Violence Intervention Project for Children and Families, our team of mental health professionals has established a strong relationship with police officers in several New Orleans police districts. Since roll call, at the time of shift changes, brings all the officers together, we have arranged to give brief presentations during roll call about the impact of violence on young children, how police officers can offer critically important emotional "first aid" in the immediate aftermath of violence, and the role of police in community violence prevention and referral.

Frequently, officers come up to us after a presentation and describe a traumatic experience that was difficult for them. Some have revealed that they have had nightmares following the event (a symptom of posttraumatic stress) and add that no one can really understand what they experienced. One officer talked about being haunted, twelve years after the event, by doubts about whether he could have done more to rescue three children trapped in a fire. Another officer sat during roll call with an angry expression, hitting his nightstick continually against his hand. After our presentation, he approached a male member of our team and talked about how frustrated he became with parents who "did not do more to control their kids." After talking with him more, we learned that this was an extremely dedicated officer who wanted to help children and families; however, it was hard for him at times to empathize with the difficulties of parents, as he observed so many seemingly uninvolved with their children. A third officer sat in the back of the room and appeared increasingly annoyed and agitated during our presentation. In the discussion period, he finally blurted out, "No one ever helped me or my family when I was shot." We offered to talk with him further after the group meeting and to assist him and his family. Psychological support is available to police officers, but usually only if they ask for it, and, as a group, police officers are unlikely to ask for help. Most feel they should be able "to deal with difficulties themselves" and many believe that even spouses or friends cannot understand what they are feeling.

Guidelines for professionals working with traumatized young children and their families

Los Angeles clinician Kathy Nader has developed some guidelines to prepare practitioners to work effectively with traumatized children (Nader, 1994). A few of them are listed below:

- **Develop a willingness to hear anything.** Be prepared to sensitively move a child or family forward through a review of horrible events.

- **Recognize the phasic nature of trauma recovery.** A child will move forward and also go backward in his or her recovery. The therapist must be able to be sensitive to these variations. The child's developmental level will affect his or her understanding of and response to traumatic events.

- **Recognize the need for occasional "time-outs" in therapy from direct focus on the trauma.** Both child and clinician may need to take care of themselves by talking about things not related to the trauma.

Whenever I bring up countertransference reactions (sometimes using different terminology) with people who work with children exposed to violence, invariably they will tell me their own stories. However, it is difficult to acknowledge these reactions, and for people outside the "mental health culture," doing so may seem like a sign of weakness. People who work with traumatized children are at serious risk of burnout; not only does their work involve high stress generally, it also brings them into frequent, emotionally searing contact with adults who do harm to vulnerable children. Providing these helpers with relief, support, and opportunities to acknowledge, recognize, and examine feelings must become an integral part of mental health professionals' educational and consultative work. Addressing burnout and countertransference should become an integral part of training and supervision for those working with young children who witness and are victimized by violence.

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Videotapes

Margie Wagner

Breaking the Cycle of Violence Produced by and available from The Latham Foundation, Latham Plaza building, Clement & Schiller Streets, Alameda, CA, 94501. Tel. 510-521-0920, FAX 510-521-9861. 26 min. $29.75.

This videotape presents child abuse, domestic violence, and cruelty to animals as interrelated crimes, symptomatic of disturbed individuals and dysfunctional families and predictive of repetitive violence that may escalate in range and severity. Animal protection officers frequently observe neglected and abused children and battered spouses. Similarly, human services caseworkers often encounter maltreated animals in the course of their work. However, officials in each system are largely uniformed as to what constitutes reportable abuse in each other's field and rarely receive cross-training from each other. Communication gaps exist among the disciplines due to differing terminologies, procedures and protocols.

This videotape and companion guide are designed to introduce caseworkers in child protection, domestic violence and animal welfare to the need for cross-training and to provide them with tools for identifying, reporting, investigating, validating and managing cases of abuse, neglect and cruelty.

Margie Wagner
Child Development Media, Inc.
Van Nuys, California 91401

Family Violence in America: The Power Within. Distributed by Altschul Group Corporation, 1560 Sherman Avenue, Suite 100, Evanston, IL 60201. 800-323-9084.

This videotape series examines the family's role in perpetuating violence in our culture today and its potential for healing. Art Linkletter serves as host; dramatic vignettes and interviews are used to illuminate the roots of violence, generational patterns and the complex feelings of trauma, shame and lost innocence caused by violence. Jane Middelton-Moz, author, therapist and lecturer on trauma, provides professional insight on the treatment of abuse victims and perpetrators. Conflict resolution skills are taught to help both victims and perpetrators clearly express their feelings without resorting to violence. The series includes the following:

Child Abuse. 22 min. $295. This program addresses generational patterns of family abuse and shows how these patterns set the stage for children to become perpetrators and/or victims of abuse in later life. Special attention is paid to the 'shame-based child' and how parents can pass destructive patterns to their children. Vignettes illustrate how therapists counsel victims of abuse and provide insight into the complex motivations of the perpetrator of abuse. The link between abuse and addiction is explored.

The Fear of Anger. 22 min. $295. This program explores the unhealthy expression of anger and provides clear examples for appropriately expressing one's feelings. Healthy anger management is taught, including positively assertive

behaviors, so that family members can replace aggressive behaviors with healthy communication.

Conflict Resolution. 22 min. $295. This program offers concrete guidelines for conflict resolution. It provides an overview of steps in conflict resolution, from "recognizing feelings" to "letting go." Vignettes illustrate both ineffective and effective anger management strategies. The tape emphasizes that possession of conflict resolution skills minimizes the possibilities for violence.

The Horror and the Healing. 22 min. $295. The program features stories of those who have endured domestic violence and describes techniques for healing individuals and families. The importance of breaking the cycle and preventing future abuse is emphasized.

Healing Our Children. Produced by CVA Media, Inc. and distributed by PsychoEducational Resources, P.O. Box 2196, Keystone Heights, FL 32656. Tel. 800-982-1055. 90 min., $89 (Continuing Education Credits available).

This three-segment program provides information on symptomatology, assessment, and treatment of traumatized children. Each segment features experts from a variety of mental health disciplines, all of whom regularly work with traumatized children. In the first segment they outline, through interviews and case studies, the complex symptoms that children experience as a result of intrafamilial trauma. Clinicians discuss post-traumatic stress disorder, attachment disorders, dissociative states, and affective disorders. The second segment explores approaches available to the therapist when beginning to work with a child, issues that guide treatment, and diagnostic and assessment techniques. The third segment presents simulations of therapy sessions and examples of the kinds of exercises that can be used when working with traumatized children. The segments also include a first-person account.

Healing Our Children, is intended for practicing mental health clinicians, pediatricians, educators, for college-level students, and for others who have professional responsibility for children of all ages.

Secret Wounds: Working With Child Observers of Family Violence. Produced by Banerjee Associates, Skillman, NJ. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. 32 min., $95.

Part I of this tape, *A Guide for Helping Professionals*, discusses the short- and long-range needs of children in domestically violent families. The video includes the perspective of a family court judge, a discussion among helping professionals, and recollections of an adult who witnessed violence in his home as a child. *Part II, Working with Child Observers of Family Violence*, which can be used directly with children, contains eight animated vignettes based on drawings by child observers (1-4 minutes each). The children's voices are heard discussing their experiences. The Leader's Guide and Activity Sheets provide materials designed to help children address the following topics: self-concept; self-esteem; labeling feelings; social isolation; safety skills; anger; not being unique; fear; problem-solving; and ownership of problem.

Setting Limits With Children. Produced by the Parents Leadership Institute, Palo Alto, CA. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. 60 min., $65.

In this lecture-format presentation, Patty Wipfler, Director of the Parents Leadership Institute, outlines an approach that puts the connection between parent and child at the center of the limit-setting process. She shows how children signal that their sense of connection is frayed or broken. She describes how to use limits and listening to help children regain their sense of connection and their good judgment. She then answers questions from the audience and demonstrates how parents can use each other as listening partners to release the stresses that make setting limits such a challenge. Included with the video is the Listening to Children series of 7 booklets: *Special Time, Playlistening, Crying, Tantrums and Indignation, Healing Children's Fears, Reaching For Your Angry Child*, and *Setting Limits With Children*.

Shaking, Hitting Spanking: What To Do Instead. Leaders Guide included. Produced by Gold Bell Productions. Salt Lake City, Utah. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. 30 min. $85.

This video presents positive nurturing parenting techniques to promote healthy, desirable behavior in children and is designed to help viewers recognize that any degree of violence toward children is inappropriate. The video and accompanying handbook are intended for use interactively with groups of parents, who have an opportunity to view typical parent-child interaction. Professional adult and child actors present difficult and challenging family situations that often lead to shaking, hitting, and spanking children. At the moment of confrontation and the use of corporal punishment, the action is stopped. Viewers are asked to consider what occurred and to brainstorm other solutions. The action is resumed and nurturing parenting techniques are presented. Rationale for the use of the alternatives is presented in a manner that does not preach, condemn or moralize. Closed Captioned.

Golpes y Gritos . . . Como Evitarlos. Produced by Family Development Resources, Inc., Park City, Utah. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. 30 min. $85.

Professional Hispanic adult and child actors present difficult and challenging family situations that often lead to shaking, hitting and spanking children. This four-part interactive video has been developed to portray cultural sensitivity to Hispanic traditions and customs. The Spanish language is spoken by professionals of different Hispanic heritages for common understanding of Cuban, Puerto Rican, Mexican, Chicano and South American families. Four parent-child situations presented are similar in content to the situations presented in the English speaking-video (*Shaking, Hitting, Spanking*). Includes Leaders Guide (in English). The video can be used as a complement to parenting programs and support groups, for training professionals and paraprofessionals, and as a resource to help prepare foster parents, high school students and others for the parenting role.

Violence and Young Children: Reducing the Risks. Includes Discussion Guide and "Successful Strategies: Addressing Violence and Young Children." from Children's Advocate (news magazine) Produced by Action Alliance for Children, Oakland, CA. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. 18 min. $40.

This tape presents the major concepts addressed at the conference "Violence and Young Children: Reducing the Risks." The tape provides an overview of issues relating to the impact of violence on children and was developed to stimulate questions and problem solving among viewers. Issues explored include 1) root causes of and risk factors for violence; 2) developmental effects on children and opportunities for intervention; and 3) the role of policy in reducing violence. This program is designed for parents, daycare providers, health and social service workers, teachers, administrators, therapists, community advocates and policymakers.

What Do I Do When?: Vol. I. Managing Normal Defiance and Aggression in Young Children. Includes trainer's manual, viewer's guide, and course workbook. Produced by Family Wise Productions, Houston, TX. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. 47 min., $150.

Helping children learn to channel aggressive impulses constructively is a crucial task of parenting. Parents may respond to defiant and aggressive behavior with aggressive punishment, which is counterproductive. This parent education program, organized into four self-contained teaching modules, discusses the concept of aggression, the role of parents in the socialization process, and basic principles for understanding and changing behavior. Specific methods of responding to defiance and aggression and strategies for teaching prosocial behavior are a key feature of the program. Program materials include 1) a videotape with concise theory, bullet point graphics and clear demonstrations using a real parent and child; 2) a course manual and parent workbook for parent-education groups; and 3) a self-instructional viewer guidebook for self-paced study at home by parents. The program's presentation of principles and skills is designed to help families from all backgrounds interact and work together in ways that prevent or reduce unnecessary conflict and foster competence and confidence.

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